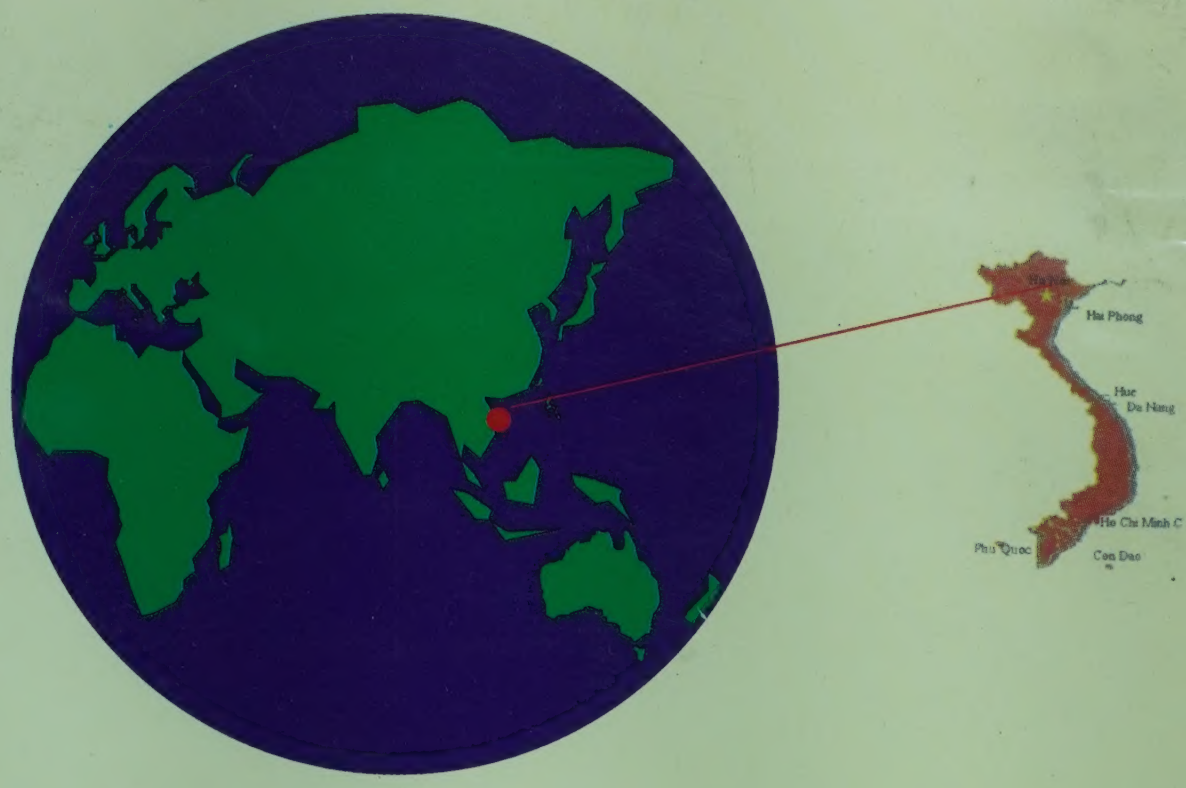

COMMUNITY-BASED REHABILITATION PROGRAM

ASSOCIAZIONE ITALIANA AIFO AMICI DI RAOUL FOLLEREAU

VINAREHA

VIETNAM

DIRECTION, APPROACH, ACHIEVEMENTS CONSTRAINTS

NHÀ XUẤT BẢN Y HỌC

AIFO **VINAREHA**

COMMUNITY-BASED REHABILITATION PROGRAM VIETNAM

DIRECTION, APPROACH, ACHIEVEMENTS CONSTRAINTS

NHÀ XUẤT BẢN Y HỌC
HÀ NỘI - 2001

Report of development of CBR program in Vietnam

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Hanoi, 09 September 2001

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List of abbreviations

ADL	Activities Daily Living
AK	Above knee
AE	Above elbow
BK	Below knee
BE	Below elbow
CBR	Community-Based Rehabilitation
CPCC	Committee for the Protection and Care of Children
CP	Cerebral Palsy
CWDs	Children with Disabilities
DF	Disability Forum
DoET	Department of Education and Training
DoLISA	Department of Labor, Invalids and Social Affairs
DPO	Disabled Person Organization
EU	European Union
EPI	Expanded Program of Immunization
GSO	General Statistical Office
HNU	Hanoi National University
HPU	Hanoi Pedagogic University
IE	Inclusive Education
INGO	International Non-Governmental Organization
MAE	Italian Ministry Foreign Affairs
MoC	Ministry of Construction
MoF	Ministry of Finance
MoET	Ministry of Education and Training
MoH	Ministry of Heath
MoLISA	Ministry of Labor, Invalids and Social Affairs
MoPI	Ministry of Planning and Investment
NGO	Non-Governmental Organization
NIES	National Institute Education and Science
NIP	National Institute Protection Children's Health
NPA	National Plan of Action
PACCOM	People's Aid Coordinating Committee
PHC	Primary Health Care
PC	People's Committee
P&O	Prosthetic & Orthotic production
PWDs	Person with Disabilities
SC	Steering Committee
SE	Special Education
TCPD	Training in the Community for PWDs
TDCSE	Training & Development Centre for SE (HPU-HNU, Hanoi)
UNICEF	United Nations Children's Fund
VIETCOT	Vietnamese Training Centre for Orthopedic Technologists
VINAREHA	Vietnam Rehabilitation Association
WS	Workshop
WHO	World Health Organization

Preface

All the project activities undertaken during the past year would be impossible without support from MoH, NGOs, and the presence of solidarity within the organisations. On behalf of VINAREHA and the Vietnamese disabled people, I would like to express our deep acknowledgement and appreciation to all who have contributed to the expansion of our Community-Based Rehabilitation program. A special and heartfelt thanks go to the Italian NGO Associazione Italiana Amici di Raoul Follereau (AIFO), we highly appreciate the contribution of AIFO for the disabled persons in Vietnam. It is commendable that the CBR project sponsored by AIFO, and started in June 1993 as pilot project in a small area, has grown into a prominent service organisation, and nowadays has been extended in five provinces supporting a large number of disabled persons. I would like also to underline the involvement of the rehabilitation unit of WHO, which has been very important in the first phase for technical guidance of the project. Last, I am very glad to present this report that aims at giving the necessary information about the CBR program only.

Prof. Nguyen Xuan Nghien

Acknowledgement

This simple report, which is mostly descriptive was done as I noticed a generally lack of documentation describing the CBR project backgrounds in Vietnam. I would like to inform the readers that I am not an "expert" but merely a "learner", I have only made an attempt to understand and document the processes undertaken by the CBR program during the past ten years in the country. As a result any errors, misinterpretations, and omissions may be considered only because of my lack of "expertise" and the informed readers may either choose to overlook such shortcomings or, better still, may want to point those out to me. I would like also to express full support, confidence, and faith in the abilities of all people at VINAREHA and those working at province, district, commune and village levels. I acknowledge with special thanks the Italian Ambassador Luigi Solari and Mr. Pietro Sequi from the Italian Embassy, and above all the assistance from individuals and officials (especially, to Prof. Nguyen Xuan Nghien, Dr. Tran Trong Hai and Dr. Pham Quang Lung), who made information available to me during the report exercise.

Scope and focus of the present report

In the broadest sense, the purpose of this report is to provide a picture of the CBR program and its achievements. In addition, AIFO wants to document lessons learnt from Vietnam that might be applicable to CBR work in other countries. It is also my sincere hope that this document will be shared at all levels from which this data was collected for continued reflection, program strengthening, and of course, corrections and modifications.

Lorenzo Pierdomenico

Region and provinces of Vietnam

North mountainous area
1. Ha Giang
2. Tuyen Quang
3. Cao Bang
4. Lang Son
5. Lai Chau
6. Lao Cai
7. Ven Bai
8. Bac Can
9. Thai Nguyen
10. Son La
11. Quang Ninh

Middle region
12. Vinh Phuc
13. Phu Tho
14. Bac Giang

Red river delta
15. Bac Ninh
16. Hanoi
17. Ha Tay
18. Hoa Binh
19. Ninh Binh
20. Ha Nam
21. Nam Dinh
22. Thai Binh
23. Hai Phong
24. Hung Yen
25. Hai Duong

North central area
26. Thanh Hoa
27. Nghe An

Median central area
28. Ha Tinh
29. Quang Binh
30. Quang Tri
31. Thua Thien Hue
32. Da Nang
33. Quang Nam
34. Quang Ngai
35. Binh Dinh
36. Phu Yen

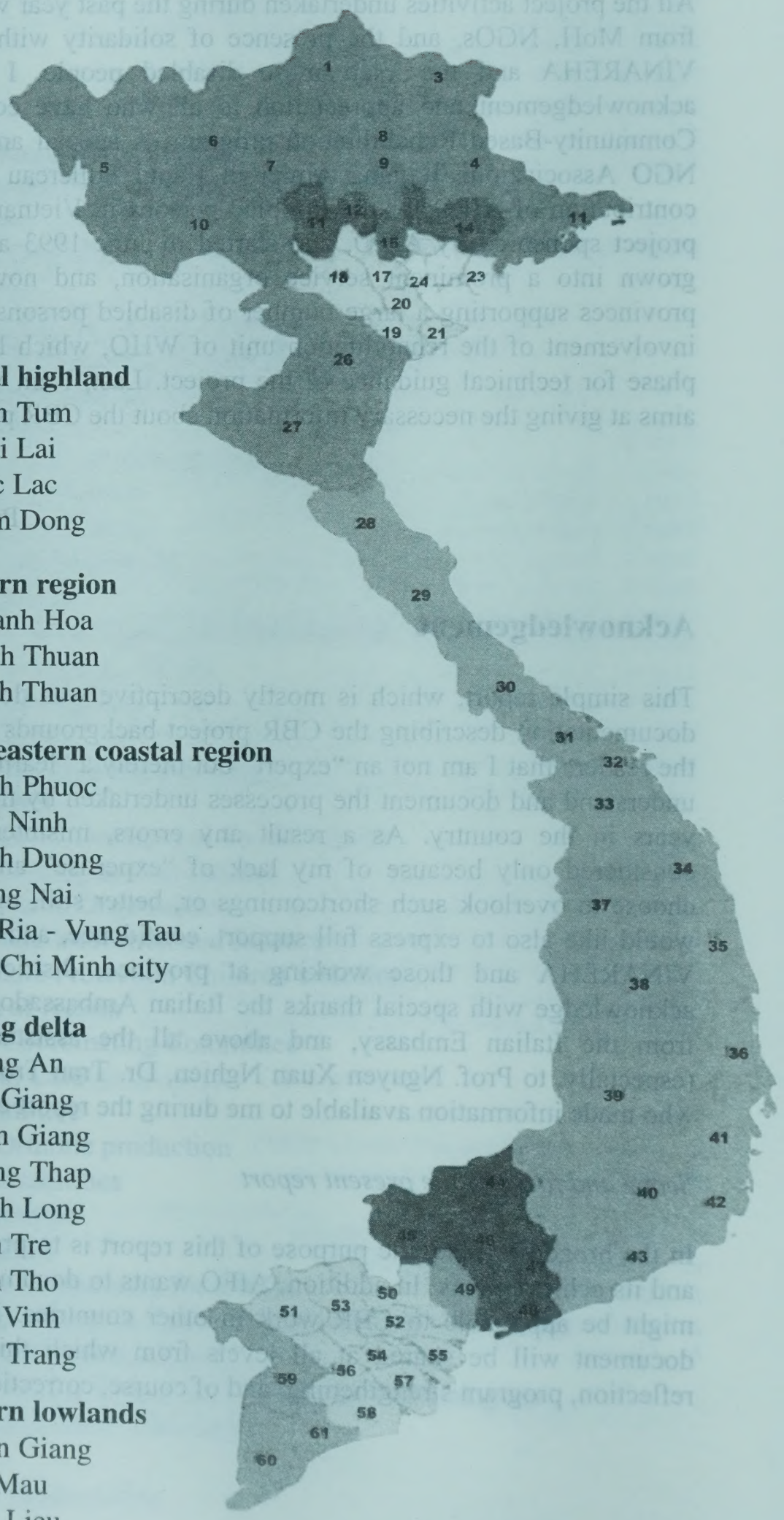
Central highland
37. Kon Tum
38. Giai Lai
39. Dac Lac
40. Lam Dong

Southern region
41. Khanh Hoa
42. Ninh Thuan
43. Binh Thuan

South eastern coastal region
44. Binh Phuoc
45. Tay Ninh
46. Binh Duong
47. Dong Nai
48. Ba Ria - Vung Tau
49. Ho Chi Minh city

Mekong delta
50. Long An
51. An Giang
52. Tien Giang
53. Dong Thap
54. Ninh Long
55. Ben Tre
56. Can Tho
57. Tra Vinh
58. Soc Trang

Southern lowlands
59. Kien Giang
60. Ca Mau
61. Bac Lieu



I. Introduction

Vietnam at a glance

AREA[1]: 331,690 km2

- 61 provinces (including four city-zones "Hanoi, Haiphong, Danang, Ho Chi Minh City", and one special zone Bia Ria "Vung Tau")
- 601 districts
- 10,330 communes

POPULATION: 77 million

- Life expectancy at birth: 67 years
- Including: 54 ethnic minorities (9 million people)
- Population growth: 1.5 million annually
- Children 0-4: 12 million
- Children 5-15: 23 million
- Total population under 18: 35 million
- Rural population: 80%

SOCIO-ECONOMY: annual GNP per capita, US$ 250[2]

- Hanoi: US$ 480 per capita
- Mountainous area: US$ 80 per capita
- Currency unit: Vietnamese dong (VND)
- Exchange rate (November 2000): 1 USD = 14,300 VND
- Transition to the market economy "Doi Moi": since 1986

POLITICS: Socialist Republic

- Stable regime
- Decentralization
- Member of the ASEAN

HEALTH[3]:

- Infant mortality rate: 45/1,000
- Under five mortality rate: 61/1,000
- Maternal mortality rate: 110/100,000
- Women delivering at home in mountainous areas: 90%
- Immunization of children under one: 94%

---

[1] Date GSO, 2000
[2] World Bank
[3] MoH

- Malnutrition:

- Protein deficiency (children under five)	45%
- Xerophthalmia	eliminated
- Iodine deficiency (population at risk)	94%
- Iron deficiency in pregnant women	52.5%

	(% population)
• Access to safe water (rural)	45%
• Access to sanitation (rural)	26%
• Childhood immunization (six antigens)	94%
• Education:	
- Adult literacy rate	91%
- Primary school enrolment rate	91% (net)
- School completion rate	61%

Vietnam, is located in the center of South-East Asia is bordered by Lao-PRD, Cambodia in the West, and China in the North. The main geographical regions are: the Coastal region, the Mountainous areas and the two large Deltas (Red River in the north and Mekong in the south). Population densities vary widely, from sparsely inhabited mountainous areas to the densely inhabited deltas. Only about 25% of the population lives in the urban centers, the rest lives in the rural areas. The administration is broken down into three levels: province, district and commune. The local units have provincial councils and People's Committees.

General context[4]

- South-East Asia is a very heterogeneous region, comprising industrialized countries such as Singapore, newly industrialized countries such as Malaysia and Thailand, and very poor countries such as Vietnam, Laos and Cambodia.
- Populations can vary from 1.2 billion people (China) to 4.9 million people (Laos). Vietnam, with 77 million people, is amongst the most populous countries in the world.
- Climate can be harsh in the region and typhoons are quite frequent in Vietnam, bringing devastating floods.
- 42% of the Vietnamese population (about 35 million) is below 18 and has no experience of war.
- In 1986 the Government of Vietnam launched the *"Doi Moi"* (revival), controlled transition towards a market economy. The on-going reforms have produced positive impact on the development of the country. Income per capita is increasing, and inflation has steadily slowed down, but the country still ranks 121st out of 130 countries analyzed in the UNDP Human Development Index. The strengthening of links with the international community has brought the country increasing international assistance. As a member of the UN and ASEAN, Vietnam is determined to become an active participant in the international community.
- Traditional strengths of Vietnam: inherited from its past, Vietnam has its disposal an extended medical and education infrastructure. Mass organizations such as the Women's

[4] Children and woman in Vietnam (UNICEF)

and Farmers' Union count millions of members. Written and audio-visual media, controlled by the Government, are available nation-wide.

- Emerging challenges: like any economy in transition, Vietnam also has to face increasing difficulties. Disparities between regions, classes and ethnic minorities are steadily rising. The introduction of fees for medical care and schools is depriving many children of their rights to health and education. The literacy rate is decreasing while the educational system has to accommodate an additional 1.5 million children every year.
- Families have seen their range choices broadened, but also their responsibilities. With the weakening of social welfare and traditional safety nets, the burden of the families, especially women, has become heavier.
- Development assistance is needed today to help Vietnam in this delicate transition period. While reforms should be encouraged, social and welfare gains made in the past should be maintained. The social needs emerging from the reforms require immediate reaction to continuously improve the situation of Vietnamese children and women.

II. Health policy and infrastructure in Vietnam

Health policy

The National Health policy is to improve awareness, and therefore, the ability to stay healthy for all the citizens. This will create an optimal health status for Vietnamese people as one important factor of community welfare. The national development efforts in Vietnam have experienced appreciable achievements and many advanced technologies have been introduced in all sectors of development, including health. The health status of the people has improved, morbidity and mortality rate of transmissible diseases has decreased and life expectancy rate at birth increased. Even though, some diseases have been successfully eliminated, eradicated or controlled, chronic and degenerative diseases are increasing as an outcome of prolonging life expectancy rate of the people.

Concerning disability, the Vietnamese Ordinance November 1998 regarding disabled persons stated that the disabled persons have equal right and opportunity in all living sectors. In other words, it means that the national direction and intention is to improve the quality of the infrastructure and the knowledge and skills of human resources. Moreover, an important element to point out, is the unprecedented rapid growth of the number of disabled persons, that is a combination of the classic processes, changing social structure increase aged population and other traumas (vehicle and industrial). Thus, while acute care has improved, chronic and degenerative diseases produce a large number of elderly disabled, and rehabilitation has become in the country an important part of the Health Policy, and is regarded as an integral part of Primary Health Care with a special program called Community-Based Rehabilitation, as a way to cope with disability alongside and with the institutional medical rehabilitation services.

Referring to the "*Declaration of Alma Ata*", the strategy for obtaining "*health for all by the year 2000*", is the Primary Health Care approach, with the implementation of inter-sectoral collaboration, community participation, and using proper and effective technology. Now, being Vietnam in the midst of a period of transition, with rapid and sometime unforeseen social changes, unfortunately, the time boundaries 2000 in Vietnam is extended to 2010, as far a result of economic difficulties.

Infrastructure

The health care infrastructure consists of an extensive network of health facilities at four main levels (central, provincial, district and commune). The Health Steering Committees is a part of the People's Committee at each level as follows:

- the provincial health service coordinates all health programs at provincial level;
- the district health service is responsible for all health programs in the district, and each district hospital covers approximately 130,000 people;
- inter-communal polyclinics at the level between district and commune, are relatively new, and provide basic care for about five communes (around 30,000 people). These have been set up for supporting PHC activities for large and under-served areas;
- the communal health center serves about 7,000 people and is responsible for PHC activities and for supervision of health workers in the communes.

Summary of health establishments[5] 1999

Establishments: 13,264

Hospital & clinics	1,857
Sanatorium	112
Medical service units at village level	11,229

Beds: 195,900

Hospital & clinics	120,400
Medical service units at village level	59,900

Health staff

Medicine	
Doctors	37,100
Assistant doctors	51,200
Nurses	45,500
Midwives	13,600

Pharmacy

Pharmacists of high degree	5,800
Pharmacists of middle degree	7,100
Assistant pharmacists	9,300

Medical staff

(as of 30-9-1999 by type of management)

	Doctor	*Physician*	*Nurse*	*Midwives*
Ministry of Health	37,277	49,013	39,835	13,483
Under direct management of MoH	5,826	418	3,428	382
Under management of provincial deprt. Of health	29,451	48,595	35,800	13,101
Under others	1,842	2,129	5,619	148

Hospital beds

(by type of management level as of 30-9-1999)

	Hospital & clinics	Sanatorium	Medical service units
Ministry of Health	112,892	2,515	49,309
Under direct management of MoH	10,700	100	-
Under management of provincial depart. Of health	102,192	2,415	49,309

[5] Bookyear 1999, General Statistic office source

Using the above figures, on average, one bed is available for up to 394 patients. It is said that curative health establishments in Vietnam have been set up, but the structure, and medical equipment are in bad conditions resulting in poor quality of curative services. Salaries of health staff at central and provincial levels and part of those at district level, are paid from the national budget. Recently, there have been changes (reduction of up to 30%) in staffing at commune level. All commune salaries are paid by the local People's Committee. The community also finances the building of the commune health centers and buys the essential drugs, and the villagers contribute either in cash or in kind.

Legislation for disability care in Vietnam

In Vietnam many people are disabled as a result of several military conflicts, that is why Vietnam has a long tradition of taking care of the disabled members of its society. In the constitution of 1946, article 14, it is stated that: "*old and handicapped people, incapable of working, shall enjoy assistance*[6]".
In 1951, President Ho Chi Minh said that everybody should receive veterans and those disabled in armed conflict into their homes and communities. He thus began an active campaign for the whole society to recognize and support people with disabilities. In the 1980 constitution, article 74, it is stated that: "*the state enacts legislation granting privileges to disabled soldiers and families of fallen combatants and creates conditions for recovering their working ability, to find employment suited to their health conditions and to lead a normal life. Persons or families who have rendered meritorious services to the revolution are commended and rewarded and receive proper care. Old people and disabled persons with no family support receive assistant from the state and the society*[7]".
In the revised constitution of 1992, article 67, under the '*Fundamental rights and duties of the citizen*' it is stated that: "*war invalids, sick soldiers, families of fallen soldiers and revolutionary martyrs will enjoy preferential treatment in state policies. War invalids will enjoy favorable conditions for their physical rehabilitation, shall be given employment suites to their state of health and assistance in securing stable living conditions. Individuals and families credited with meritorious service to the country shall be given commendation and reward and shall be looked after. Old people, infirm people and orphans without support shall receive state assistance*[8]".
Last, but not least the importance and relevance of the Disability Ordinance issued in November 1998 which encompasses all the disabled including those are war veterans.

Government structure in Vietnam

The administrative system is divided into four levels[9]:

Central:	governs all cities and provinces nation-wide
City & province:	governs all districts
District:	governs wards and communes
Ward and commune:	grassroots level (each ward/commune is divided into household areas "urban or hamlets rural")

[6] The Gioi Publishers (1995)
[7] The Gioi Publishers (1995)
[8] The Gioi Publishers (1995)
[9] Refer Chart 1

Each level has its own executive body and functional agencies such as: Health, Education, DoLISA as Department of Labor, Invalids & Social Affairs, CPCC as Committee for the Protection and Care of Children. Other than that, there are also mass organizations such as: Red Cross, Labor Union, Fatherland Front, Women's Union, Youth Union and so forth.

Disability prevention

Primary Health Care
PHC and improvement of quality of health care are the two main tasks of health services, which includes the concepts of preventative medicine, the rationalization, and maximization of local resources and international assistance are emphasized among others.

Health worker
Basic health workers, serve at the commune level under the supervision of a communal health station and are responsible mainly for disease.

Communal health station
A communal health station is built in each commune with six-seven thousand people on average. PHC provided by the station includes: immunization, prenatal, examination, dental care, delivery, minor surgery and CBR services. It is staffed with an assistant physician, a nurse and a midwife. An inter-communal polyclinic staff in the community has the same function, but the service is more extensive due to better facilities.

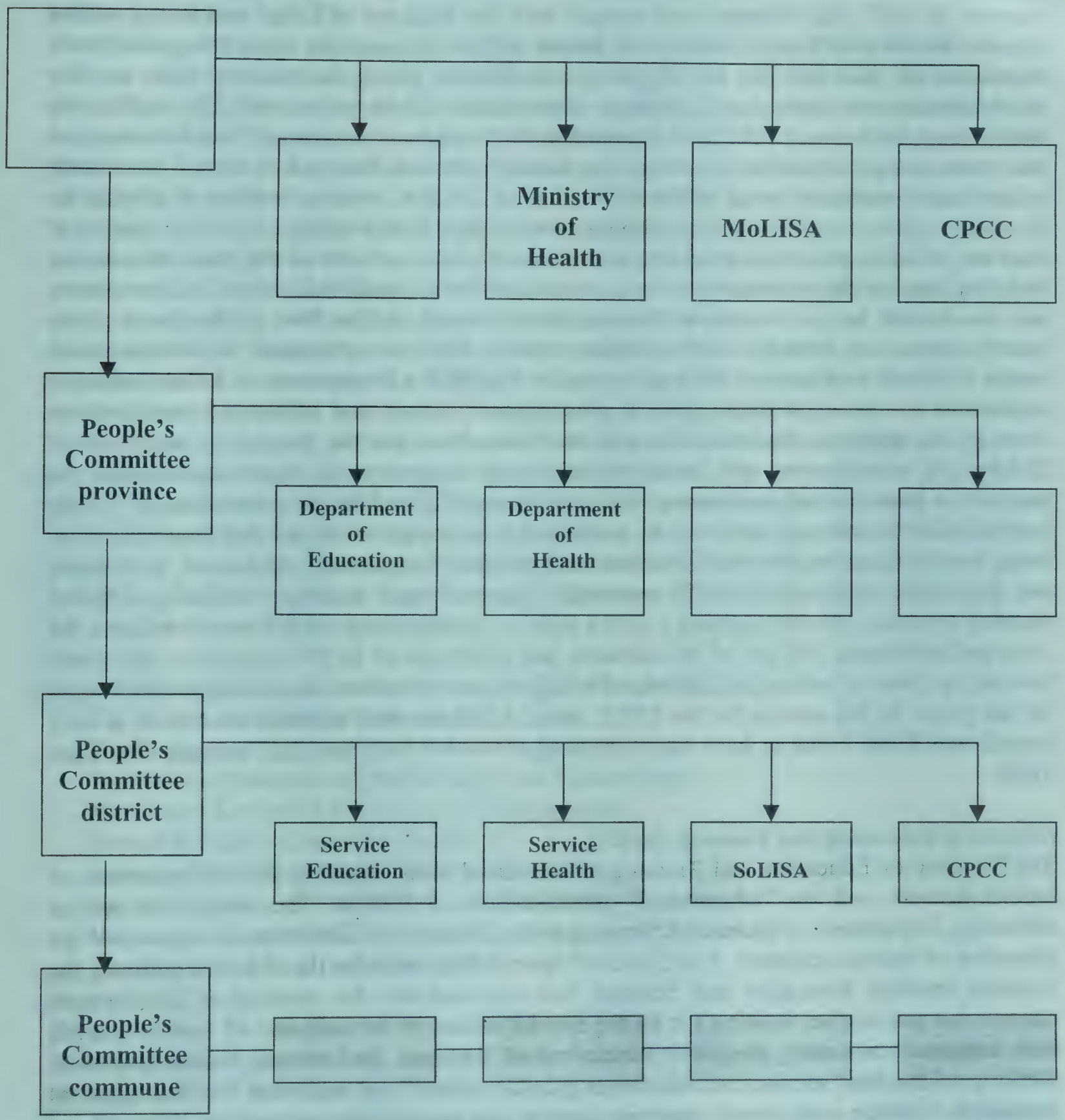
At the district level
District general hospital provide treatment. In addition, hygienic and epidemiological brigades serve to control malaria and provide vaccination.

At the provincial level
These are general and specialized hospitals, social disease dispensaries which especially deal with trachoma, goitre, venereal skin diseases and mental illness, sanatoriums, maternal protection and family planning, rehabilitation departments.

At central level
Disability related matters are broadly divided into '*medical*'', '*social and vocational*' , and '*educational*' services, and are dealt with respectively by the Ministry of Labor, Invalids and Social Affairs (MoLISA), the Ministry of Education and Training (MoET), and the Ministry of Health (MoH).

Chart 1

The administrative system and functional bodies in Vietnam



Amongst these organizations and services the following are responsible for working and dealing with disability: Health, Education, DoLISA and CPCC; of which the latter takes main role in supervising and monitoring activities concerning the care of the children carried out by the other three.

Ministry of Labor, Invalids, and Social Affairs (MoLISA)

The Ministry of Labor, Invalids, and Social Affairs is responsible for social welfare and job replacement. In the 1940s, the Government established the Ministry of Invalids to care for veterans. In 1987, this Ministry was merged with the Ministry of Labor and Social Affairs into the Ministry of Labor, Invalids ad Social Affairs. Among the three Ministries above mentioned, the MoLISA has the biggest responsibilities. Under the Minister there are four vice-Ministers who supervise 12 different departments. There are no MoLISA staff at the district level and below. MoLISA is responsible for "*social and vocational*" rehabilitation, job placement and social welfare in general for disabled persons. This task is carried out mainly by the local department social affairs offices called DoLISA. A large number of schools for disabled children are still under the responsibility of MoLISA, because vocational training of disabled children was considered the main task of these schools in the past. In addition MoLISA has also the responsibility for a certain number of small child rehabilitation centers, and also for the largest vocational training center located in Thu Duc, in the South of the country. Moreover, linked to some of these centers there are orthopedic workshops where simple to rather sophisticated devices are made. MoLISA's Department of Rehabilitation is responsible for the eight larger general rehabilitation centers and orthopedic workshops in Vietnam. In addition, the MoLISA and the Committee for the Protection and Care of Children, in coordination with other ministries and organizations, have implemented the program to take care of, and protect children in especially-difficult circumstances[10]. They provide children with opportunities to study and learn simple skills so that they can afford living conditions to become useful citizens and integrate into society. At present, in 61 cities and provinces, there are 531,096 especially disadvantaged children, including 232,966 disabled children, 147,501 orphans (32,314 with no patrons), and 15,891 street children. All cities and provinces, 308 out of 563 districts, and 3,698 out of 10,291 communes and wards have set up plans of action for children, of which 43 provinces have fixed their annual budget for the plans. At the centers for the CPCC about 4,000 disabled children are treated at their homes, and 5,000 children have been operated with cleft and hare lips through Operation Smile.

Ministry of Education and Training (MoET)

The Ministry of Education and Training is concerned with disability for administration of special schools and on "educational" rehabilitation of CWDs. The section of special education, Department of General Education in the Ministry of Education is responsible for education of disabled children. The Center of Special Education for the impaired children, the National Institute Education and Science, has responsibility for curriculum development supervision and teacher training for all the special education schools and all normal schools with integrated education (Inclusive Education) in Vietnam. The 16 educational specialists working in the four sections at this center provide educational expertise for four types of handicaps children with *visual, hearing, speech* and *intellectual* impairment. The task of educational rehabilitation is carried out at local level by the educational affairs offices and "mainly" by the motivated school teachers. While, the Center for the Handicapped, which is one of the five centers of the Children Fund in Ho Chi Minh zone, has the responsibility for coordination of all matters concerning special education (including teacher training). In the South a new National Center for Educational Science and Training, is been established under

[10] Vietnam Committee for Protection and Care of Children source

the responsibility of MoET, which will also claim responsibility for teacher training (including Special Education).

Ministry of Health[11] *(MoH)*

The Ministry of Health is responsible for prevention, early detection of disability, and also for medical rehabilitation through the network of Primary Health Care services. Rehabilitation services, have until recently been restricted mostly to physiotherapy departments in provincial hospitals and some specialized centers. At this moment, a total of 34 provincial hospitals have established physiotherapy-rehabilitation departments. Besides these departments most specialized hospitals in Hanoi and in Ho Chi Minh City, have their own rehabilitation department. Unfortunately, this hospital-based approach has resulted costly, extremely inconvenient and accessible by only a minority of disabled persons. Besides, it has been considered that the physiotherapy-rehabilitation departments require highly trained personnel which are usually in short supply, specially at the district or commune level. Because of this, the majority of the disabled persons did not have access to those rehabilitation centers. That is why, the MoH has developed the strategy for integrating CBR approach in the PHC system and has carried out CBR activities in many provinces. With the introduction in Vietnam of CBR approach a broader definition of rehabilitation has been adopted, encompassing social and educational aspects. Furthermore, it has been adapted the curriculum at the medical schools to be better orientated on CBR approach. CBR program is implemented in Vietnam by and through a system of Steering Committees at national, provincial, districts and community level. Representatives of the People Committees, health, educational and social authorities are all members of these Steering Committees. Moreover, ten specialized institutes are attached to the Ministry of Health:

- The National Institute for the Protection of Children's Health;
- The National Institute of Nutrition;
- The Institute of Hygiene and Epidemiology;
- The National Institute of Dermatology and Venereology;
- The Center for Health Education and Propaganda;
- Human Resource Center for Health;
- Institute for the Protection of Mother and Infant;
- National Institute of Tuberculosis and Respiratory diseases;
- National Institute of Malariology, Parasitology, and Entomology;
- The Institute of Traditional Medicine.

Other bodies

In 1992, Vietnam upgraded the National Plan of Action (NPA) for Vietnamese children and consolidated the Committee for Protection and Care of Children. At the National level CPCC has the status of a ministry for the management of activities on protection and care of children nationwide. At provincial, district and commune levels, local CPCC's were set up to carry out the assigned mandate.

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[11] Refer Charts 2 - 3

Chart 2 **HEALTH CARE SYSTEM IN VIETNAM**

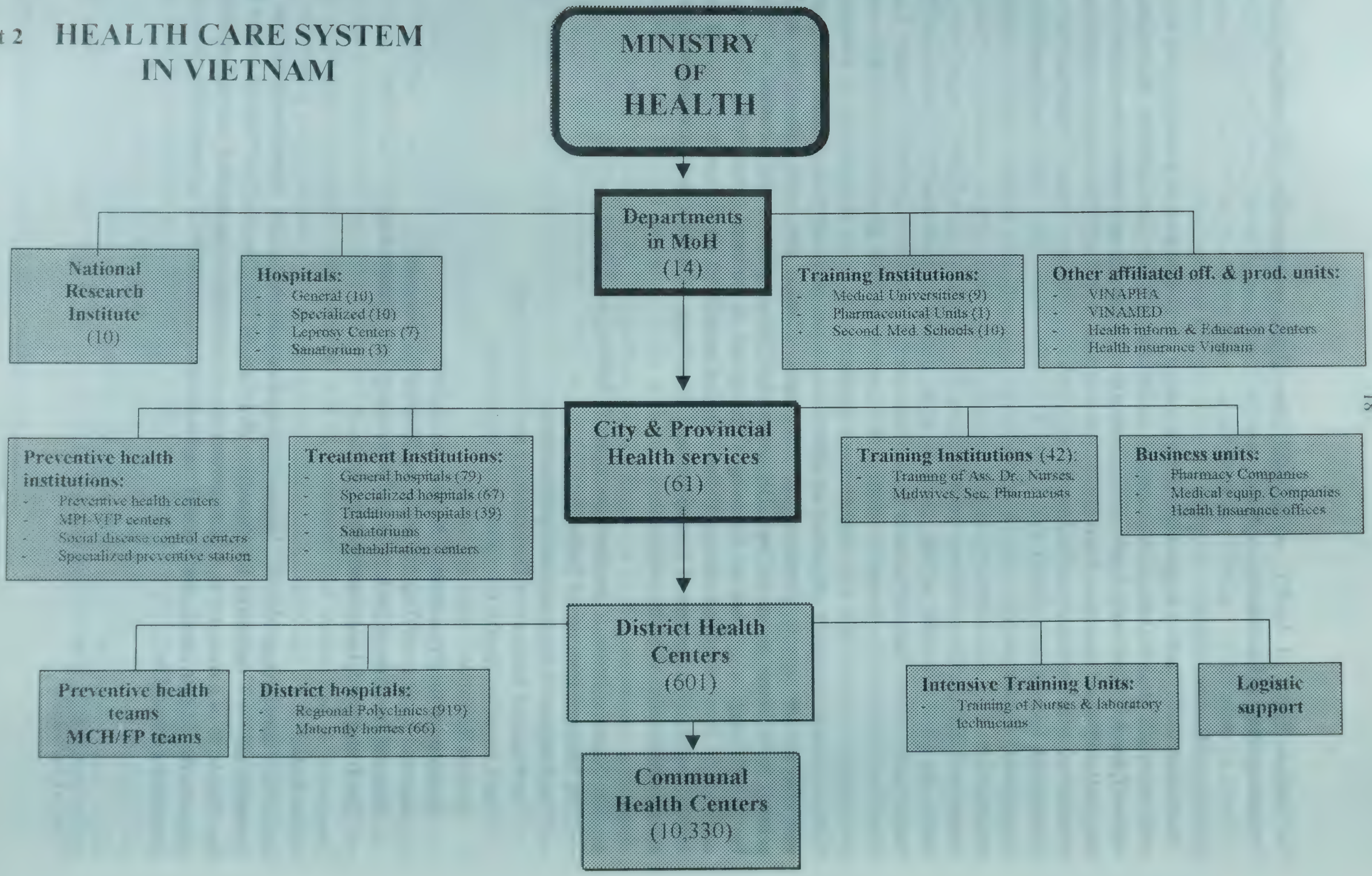
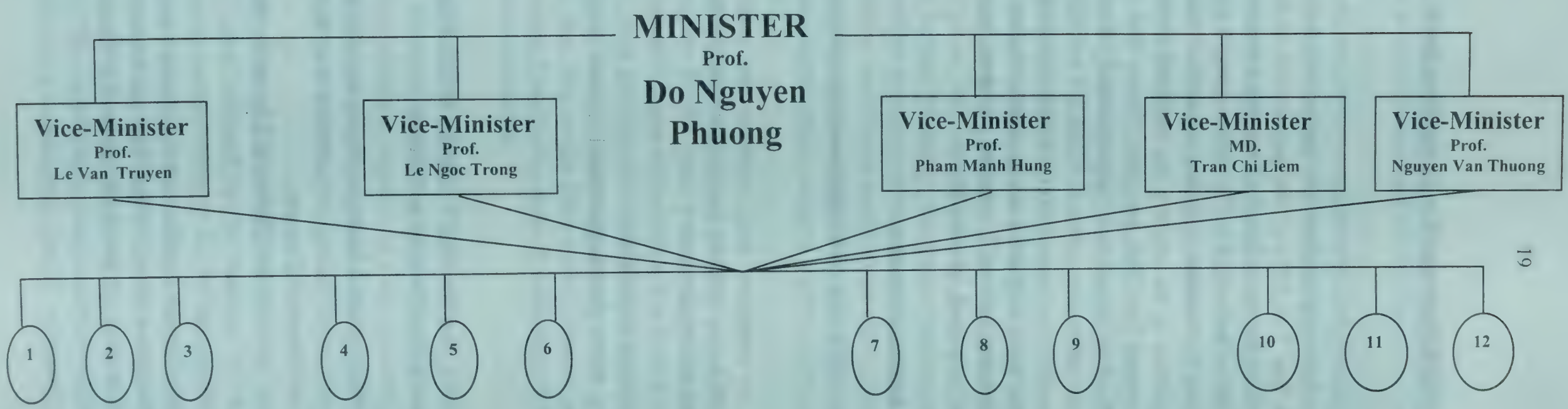


Chart 3

Ministry of Health - Socialist Republic of Vietnam



The functioning Departments in the MoH:

1. Health Personnel (845.25.46)
2. Planning (Dr. Duong Huy Lieu, 846.40.58)
3. Therapy (Dr. Tran Thu Thuy, 846.24.15)
4. Hygiene & Epidemiology (Dr. Hoang Dinh Hoi, 846.23.64)
5. Traditional Medicine (846.43.13)
6. Science & Training (Prof. Nguyen Van Dip, 846.49.18)
7. Dept. of Maternal, Children & Family planning
8. Dept. of Administration (Dr. Nguyen Vy Ninh, 843.58.12
9. Dept. of International Co-operation (Dr. Tran Trong Hai, 846.05.93)
10. Dept. of Medical Equipment and Construction (Mr. Duong Van Tinh, 846.48.23)
11. Dept. of Finance (846.23.61)
12. Dept. of Legislation (823.69.70)

III. Facts on disability and education in Vietnam

Disability and education

Rehabilitation problems in developing countries are important part of total health. The literature care generally agrees that 7 to 10% of the population in developing countries is disabled (official figure from WHO for the number of disabled people in general is 10% of the population). Of this, 30 to 50% of them (2.5 to 3% of the general population) is in need of rehabilitation or special education. In Vietnam, reliable surveys of MoLISA in recent years show that 5.2% of the total population in the country are disabled. Preliminary data collected by MoH from 25 provinces covered by CBR program shows that the percentage of the disabled persons comprises 5-7% of the population (approximately 4 million). These numbers also coincide much more with the estimation given to UNICEF by NIES, that the number of disabled children under 15 years (40% of population), which includes all different types of handicaps, of those 30-50% of the total of CWDs needs rehabilitation and special education, more than 150,000 children. Currently, of these 150,000 children, only about 3,000 receive the type of special education that they need, or only 2%.

Classification of impairments and disablement

The WHO identified seven major categories of disabilities in its international classification of impairments and disablement:

1. Mobility impairment; such as amputees (e.g., leprosy can lead to severe disability), paralyzed persons, people with polio, cerebral palsy, clubfoot or other birth defects.
2. Hearing/Speech (communication) impairment.
3. Visual/Seeing impairment.
4. Learning (cognitive or intellectual) impairment.
5. Strange Behavior, resulting from psychotic/mental illness (e.g., schizophrenia and depression).
6. Fits/Epilepsy.
7. Other impairments.

The Vietnamese MoLISA, the MoH, and the MoET use the WHO definitions of impairment, disability, and handicap, which are defined briefly as follows:

- **Impairment*** (organ level): loss or abnormality of body structure or of a physiological function (e.g., loss of a limb or loss of vision). Impairment may be the result of disease or accident, or of congenital or environmental agents.
- **Disability*** (individual level): reduced or absent ability to perform as a result of an impairment. The restriction or absence of a function (e.g., moving, hearing or communicating).
- **Handicap** (social level): disadvantages experienced by a person as a result of a disability. The result of an interaction between an individual with an impairment or disability and barriers in the social, cultural or physical environment so that this person cannot take part

in mainstream community life on an equal level or fulfill a role that is considered normal (depending on age, sex, social and cultural factors).

* It is important to realize that *impairments* and *disabilities* may be visible or invisible, temporary or permanent, progressive or regressive.

Along with the seven main types of disabilities categories previously mentioned above, another special category of persons with "multiple disabilities" needs to be clearly identified. Persons with multiple disabilities have special service needs and present special challenges to policymakers and service providers.

Major strategies for rehabilitation

Institution-based rehabilitation services
Is provided in a residential setting or in a hospital where disabled people receive special treatment or short-term intensive therapy. The institution-based approach focuses on the person's disability and gives little attention to the person's family and community, as well as to other relevant social factors. Probably, the major shortcomings of institution-based care are its high cost and its location, usually in urban centers, making it inaccessible to those living in outlying areas, in addition, specialized institutions often lack qualified personnel. However, competent institution-based care, is an important part of the rehabilitation referral system for the provision of special assessments, surgical interventions, or other skilled treatment, and specialized equipment.

Outreach rehabilitation services
Are typically provided by health care personnel based in institutions. Such a program provides for visits by rehabilitation personnel to the homes of disabled people. The focus is on the disabled person, and perhaps the person's family. Education and vocational training are generally not included in it. Community involvement in these services is usually very limited, with the result that they evoke little social change, and the cost per person treated is quite high. For sure, outreach services can be a valid part of the referral system, but probably only when used in special situations.

Community-Based Rehabilitation (CBR)
The CBR approach, is characterized by the active role of disabled persons, their families, and the community in the rehabilitation process. In CBR philosophy, knowledge and skills for the basic training of disabled people are transferred directly to disabled adults themselves, to their families, and the community members.

What is Community-Based Rehabilitation?

CBR strategy is a common-sense strategy for enhancing the quality of life of the disabled persons by improving service delivery reaching all in needs by providing more equitable opportunities, and by promoting and protecting their rights. CBR builds on the involvement of disabled persons and their families. It should be supported by all levels of society, and it seeks the integration of the interventions and combined efforts of all relevant sectors of the services. Hence, CBR is a socialized health program, mobilizing several resources

contributing to the assistance for the PWDs right at the community. Let us try to explain it word by word:

- *Community:* every group of people living together in the same area, with the same culture, religion, and so on. Maybe economical depending on each other.
- *Based:* in the community with the participation of the community and finally owned by the community.
- *Rehabilitation:* there are four areas where rehabilitation is needed: Physical, Social, Educational, and Economical.

Rehabilitation

Includes all measures aimed at reducing the impact of disability for an individual, enabling him or her to achieve independence, social integration, a better quality of life and self-actualization. Rehabilitation includes not only the training of disabled people but also interventions in the general systems of society, adaptations of the environment, protection of human rights and empowerment. Disabled people shall have the same rights to a life in dignity as others. A brief definitions of the four areas could be as follow:

a. *Physical rehabilitation:* all activities to rehabilitate the functions of the body with the purpose to make the person as much independent as possible. This can happen in the community or in a special centers (e.g., hospital, etc.);
b. *Social rehabilitation:* all activities to rehabilitate the disabled persons in the community, which mean that this person has access to all social activities of the community. Thus, attitude towards disabled persons should change among the society to the normalization and integration;
c. *Educational rehabilitation:* it means that children with disabilities have access to regular school or special education, and this should also be the fact for adults. Disability and poverty are linked together and poverty and education are also linked together;
d. *Economical rehabilitation:* all activities related to make disabled persons independent. It is necessary to address efforts to their economic situation.

In other words, rehabilitation means *to bring back on the level before or if that is not possible to bring back on the highest possible level.*

So, why CBR?

Because, CBR strategy is one response to the *"inappropriate and often insufficient"* institutional services. Anecdotal evidence from other countries indicates, that the CBR approach can be expected to meet the needs of 70% of all PWDs, compared to institutional rehabilitation, which does not cover more than 1-2% in most countries. CBR programs aim at giving comprehensive services to disabled persons where they are living, in fact is mainly home based, and use for rehabilitation the resources available in the community. CBR strategy means large scale transfer of knowledge, and skills to the disabled persons, their families, and members of the community. Currently, in developing countries CBR approach seems to be the only way to provide services to the disabled persons and their communities.

Goals and objectives

The goal is to bring about a change, to develop a system capable of reaching all disabled persons in need, besides to educate and involve governments and public authorities in order to

improve the disabled persons' quality of life, by changing the attitude of the communities towards disability and by improving disabled persons capabilities and self-reliance. The major objective of CBR program is to ensure that disabled persons become able to maximize their physical and mental abilities, have access to regular services and opportunities, achieve full social integration within their communities.

Methods for implementing CBR

The broad methods for developing CBR program include the formulation and implementation of policies to support it, namely:

a. To encourage and support communities to assume responsibility for the rehabilitation of their members who have disabilities.
b. To strength rehabilitation referral services for health, education and labor at district, provincial and national level.
c. To establish a system for program management, monitoring and evaluation.

CBR is not a single program blueprint, but an underlying set of values which should be applicable everywhere. Some of these values are:

- emphasis on changing attitudes;
- promoting accessibility;
- participation of disabled people, and involvement of their families;
- taking a holistic view of the disabled person;
- tackling the three levels of disability prevention;
- use of existing resources;
- integrating disability in development.

Sustainable CBR programs

A CBR program can be sustained when three factors come together:

a. The articulation of a need from the community.
b. A response from within the community indicating readiness to meet this need.
c. The availability of support from outside the community.

An isolated CBR project, which is not related to some Government policy or program, has very limited chance of being sustained. Sometimes an organization, in its zeal to promote CBR, provides a great deal of external support to a CBR project which is not linked to Government policies or priorities. There may be a perceived need, and the community may be enthused, because of the initial external support. However, gradually as the external support decreases often the CBR program may wither first and die later. In many countries the catalyst for introducing CBR program has been one or more NGOs, elsewhere the program has been introduced on a national level by government. However, whatever the point of initiation, for a program to be sustainable it needs to be closely linked with the "*government infrastructure*". In practice there is a great range of activities that are subsumed under the heading of *"CBR"*.

IV. The national CBR program context

The project's history

CBR program in Vietnam was started in 1987. Referring to the success achieved in Tien Giang province (South of Vietnam), and realizing the weakness in the traditional way of providing services for the rehabilitation of disabled persons, the government of Socialist Republic of Vietnam has adopted CBR approach as a national strategy to cope with disability-related matters. In Vietnam, CBR program has its own local touch, both differing from the model of the WHO manual, and from other CBR programs in the world. It is not only different from these, it also varies within the Vietnamese context, from province to province, although there is an overall framework giving the program consistency.

The legal basis for CBR

The 1989 Law for the Protection of Children's Health states that CBR advocated by WHO would henceforth be the National strategy for giving services to the disabled in Vietnam. Article 23 of this Law solicits that MoH, and MoLISA must provide the necessary facilities for rehabilitation centers, besides to cooperate with the related branches and social organizations to broaden the scope of CBR in order to prevent and limit the impact of disability and to use appropriate measures to help disabled people lead a normal life. Moreover, Article 47 of the same Law specifies that the care and rehabilitation of CWDs involves the responsibility of MoLISA and MoET.

The synopsis history of CBR development in Vietnam

Since 1987 up to now, CBR program has developed very rapidly in Vietnam as follow:

- 1986 first contact between Dr. Tran Trong Hai and Save the Children/Radda Barnen Swedish (RBS) and proposal for CBR;
- January 1987, translation of the WHO manual "TCPD" into Vietnamese by Dr. Hai and his staff;
- March 1987 national CBR workshop conducted by Dr. P. Mendis (six pilots communes, Cai Lay district), in Tien Giang province and one commune in Ho Chi Minh City;
- March 1988 one year evaluation;
- 1989 extended to more provinces;
- 1990 started Integrated Education for CWD;
- 1991 started the support from other NGO's[12];
- 1994 started AIFO support;
- 1997 official strategy plan for CBR in Vietnam by MoH (CPCC, NIES);
- November 1998 new Ordinance on Disabled Persons in Vietnam;
- 1999 establishment of the Disability Forum[13];
- 2001 establishment of NCCD.

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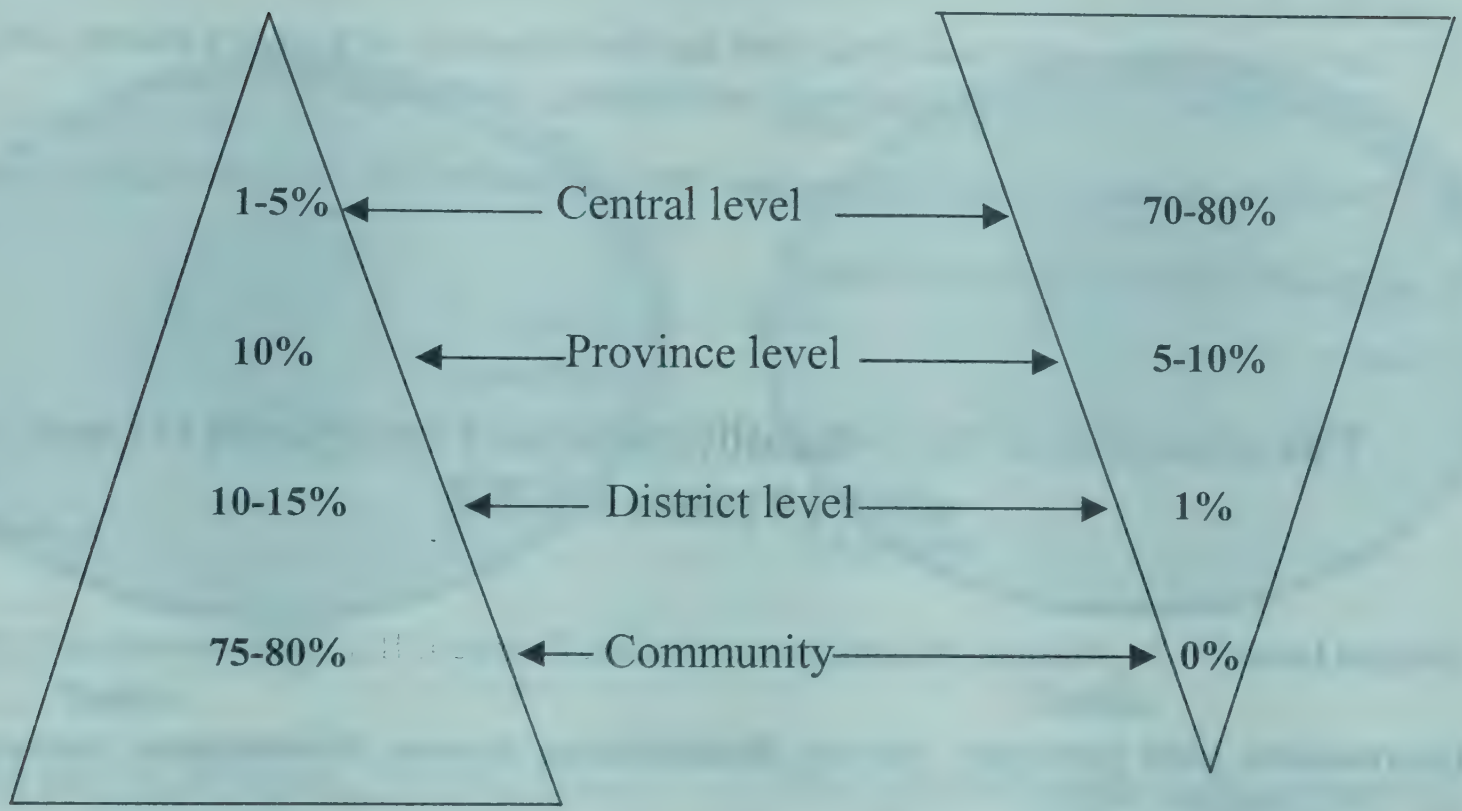
[12] Appendix a
[13] Appendix c

CBR in Vietnam

The situation of rehabilitation personnel to PWDs.
A survey conducted in 1986 showed the following findings:



Distribution of the PWDs who can be rehabilitated

Distribution of the rehabilitation personnel

The training system for rehabilitation personnel tended to train personnel with skills helping the disabled persons in the urban and more developed areas only. From the pyramid one can very clearly to see the misallocation of rehabilitation personnel and the needs of PWDs to be met in terms of disabled person whose needs are thus poorly met.

Objectives of CBR program since 1987

1. To establish a CBR model fully integrated in the PHC system;

2. To establish a system of training rehabilitation personnel from top down and bottom up. To develop a comprehensive rehabilitation system which consists of four components:

    - Medical
    - Educational
    - Social
    - Vocational training, income generation

3. To evaluate all impacts of CBR, give recommendations to MoH and the government to issue necessary legislation and policy.

Legislation and policy

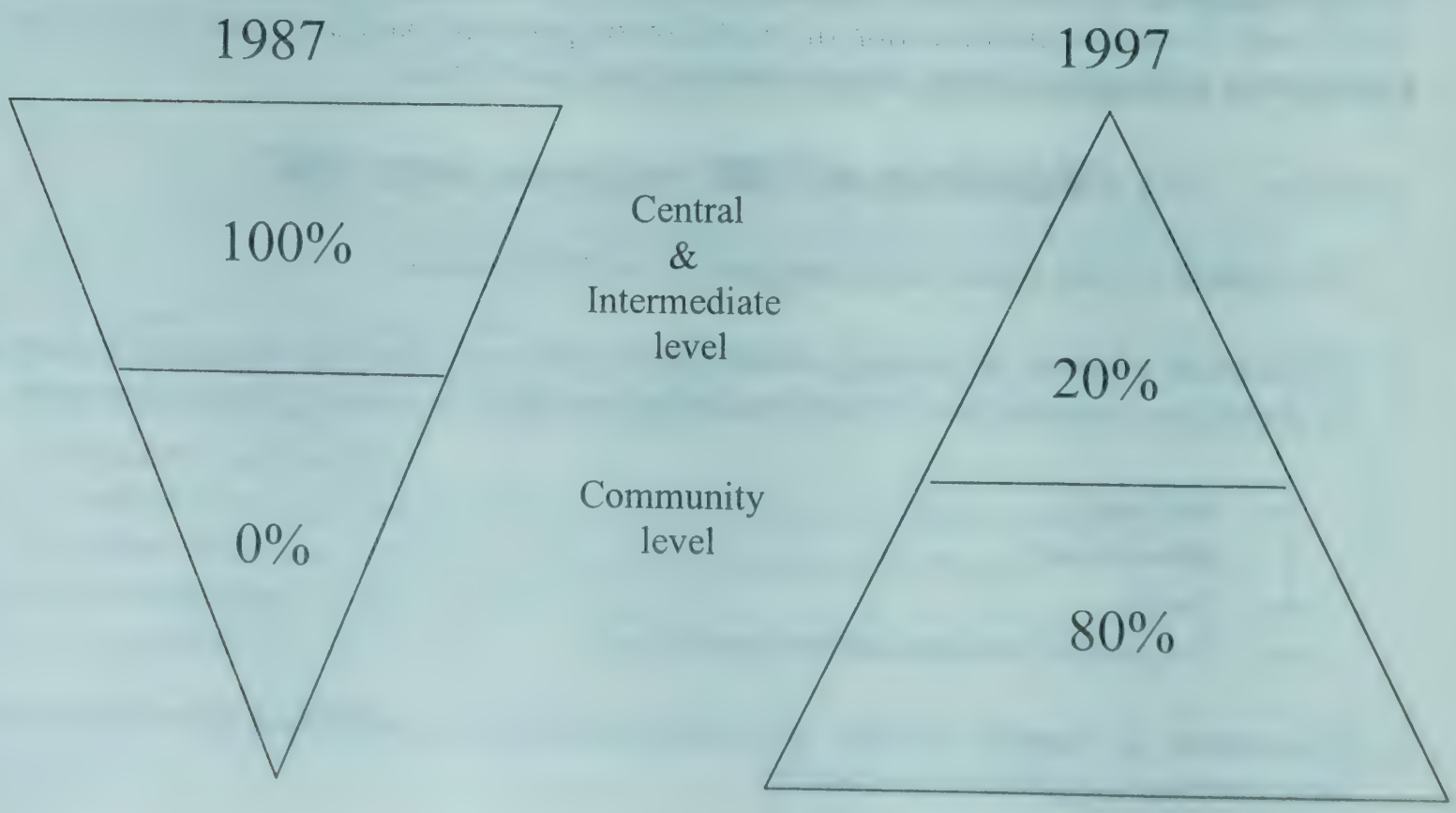
1. MoH issued a general strategy to develop rehabilitation and CBR in 61/61 provinces by the year 2020.
2. The National Assembly passed the 1989 law for Protection of People's Health with one chapter stating *"CBR should become a main strategy in Vietnam"*.
3. Disability Ordinance issued in November 1998 and reviewed in December 2000.
4. Establish a State Coordinating Body.

The situation of the rehabilitation staff categories trained after 10 years of CBR

Central level: Ph.D., Masters, Rehabilitation doctors, Degree I, II, (CBR trainers) = > 120

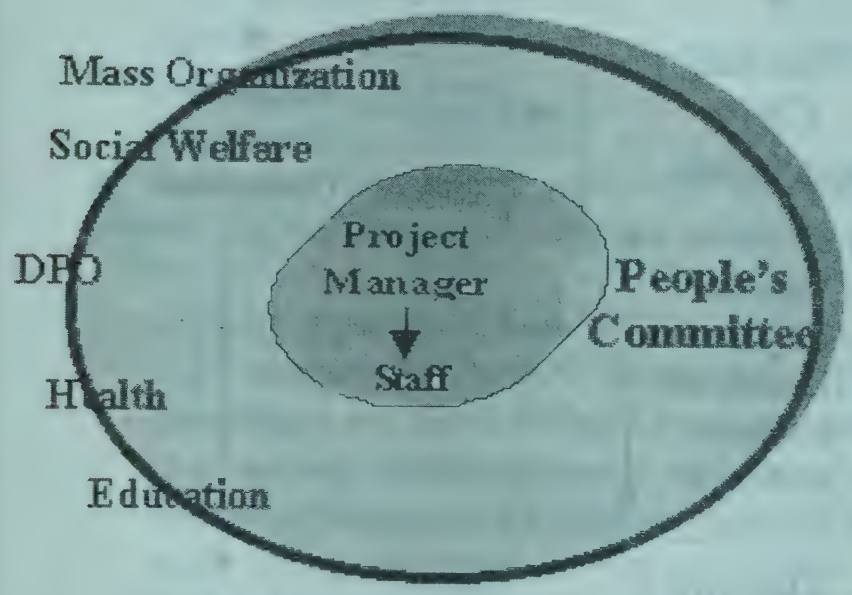
Intermediate level (province, district)**:** Rehabilitation doctors, Rehabilitation technicians, and CBR trainers = > 550

Community level: CBR workers, Volunteers = > 10,000



Organization of CBR network in Vietnam

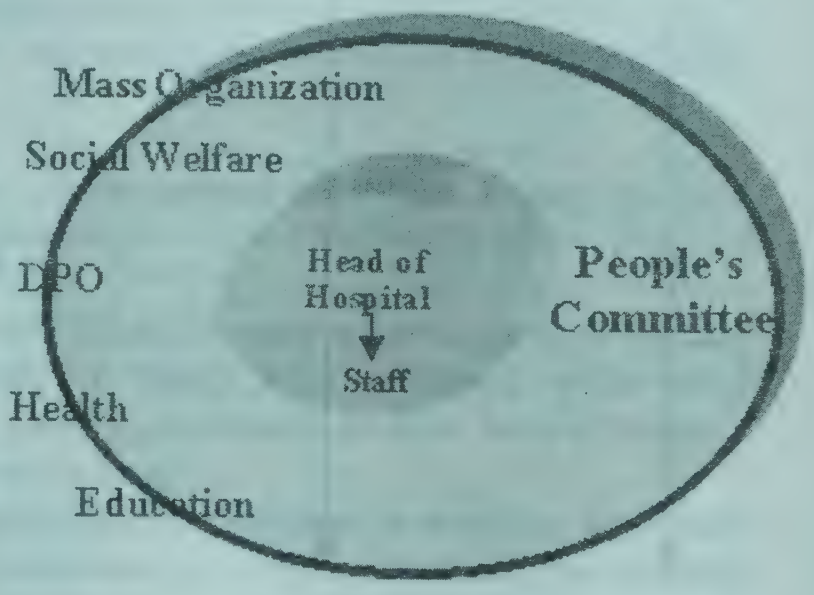
Province



Tasks:

- Problem analysis, Planning, Training, Monitoring

District



Tasks:

- Train volunteers, to motivate-guide-address CBR workers, and Monitoring

Commune

Head of the health center

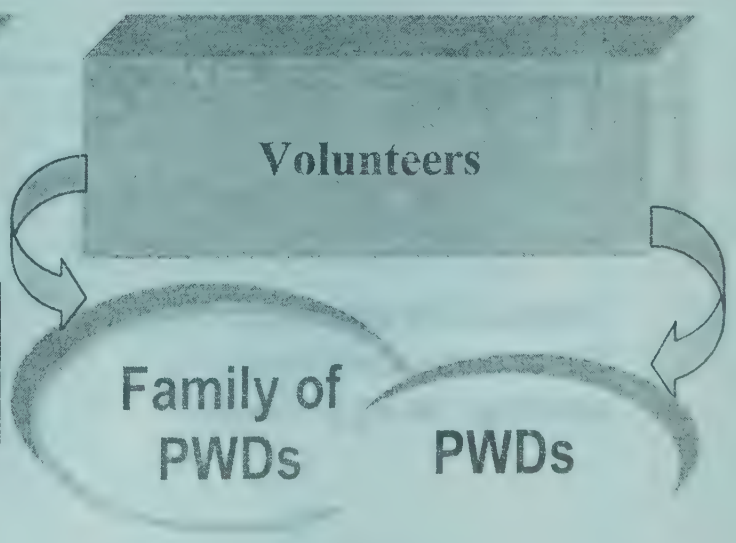
Local Supervisors

Nurses	Social workers	Teachers	Women	Mass Organizations

Tasks

- Community awareness, Train volunteers, Support & supervise volunteers, Report & record

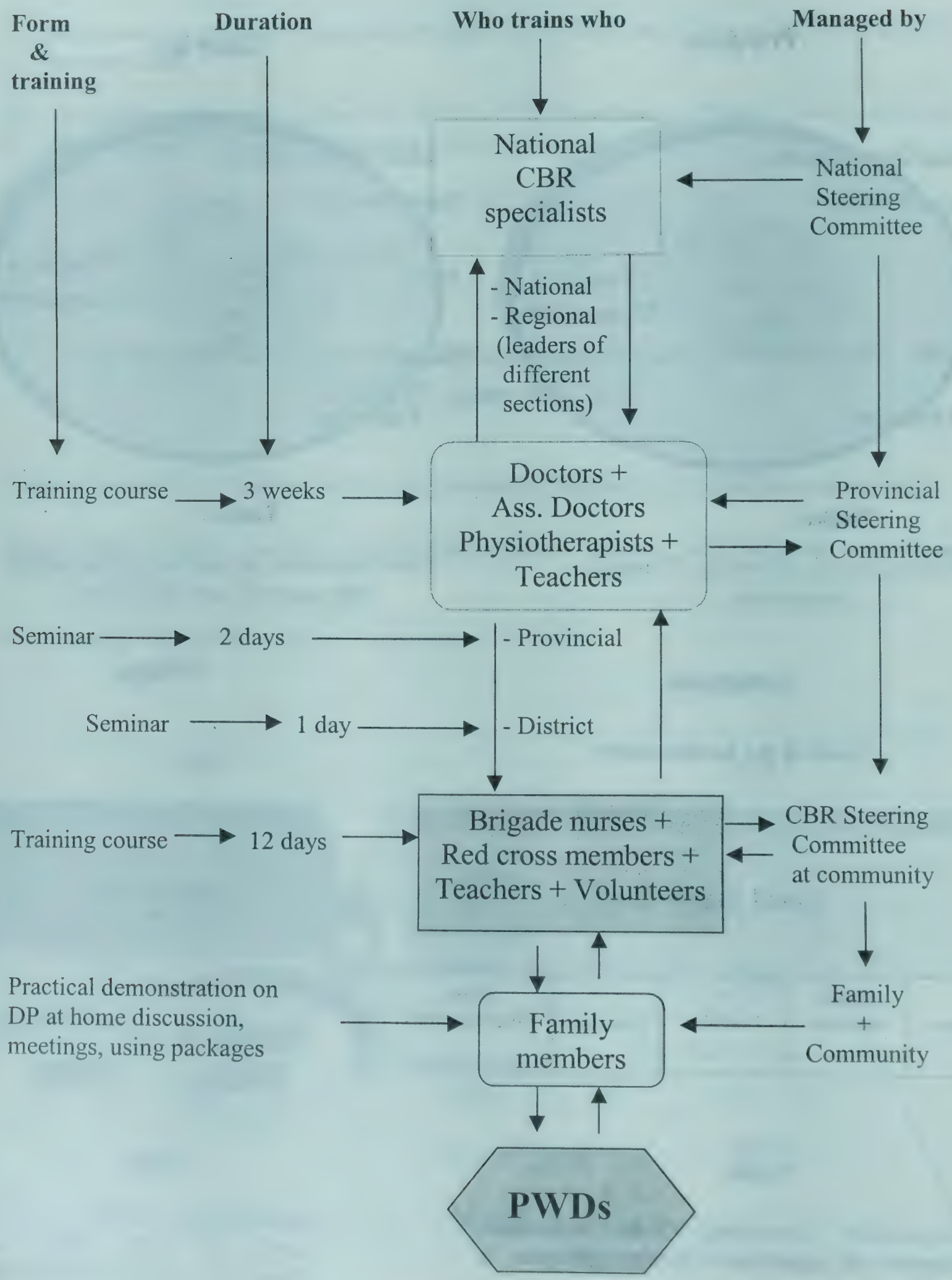
Village



Tasks:

- Identification of PWD, Training the family of PWD, Make simple orthopedic technique, Refer PWD to:
  * Health, Education, Vocational training, job

Model of development and training for CBR in Vietnam



Disability data used

In Vietnam, the causes of most disabilities fall in four major categories: Congenital, Diseases, Traffic-Work accidents, and Environmental agents (including war). The main sources and types of data on disability available in Vietnam are as follows:

- Special surveys conducted by MoLISA and MoET/NIES and their collaborating NGOs;
- CBR data collected by MoH, CPCC, and collaborating NGOs;
- Service statistics from rehabilitation centers and orthopedic workshops run by MoLISA, the DoLISA, and MoH.

In this report, in making numerical estimation of the number of PWDs among the total population, we should consider the following problems:

- defining types and causes of disability, as some disabilities are easier to identify visually (e.g., amputees, Down's syndrome persons, or totally blind persons), while other disabilities are more difficult to assess and confirm, especially in their level of severity (e.g., speech, strange behavior, or level of hearing loss).
- numerical estimates for various types of disabilities for Vietnam as a whole, have been made using estimates of the percentage prevalence of disabilities from two national MoLISA surveys and/or from MoH-CBR data.

In addition, numerous disability project evaluations, needs assessments, and likely situation analyses have generated new data on PWDs and rehabilitation services, and have provided additional insights into the issues, problems, and program needs in the disability and rehabilitation field. Moreover, because program coverage is not complete and training of program staff in data collection is often limited, likely disabilities are underestimated or misdiagnosed. On the other hand, in the absence of reliable disability data collected from independent sources, we can only estimates the number of PWDs. Hence, the following tables and figures want to be illustrative and should not be viewed as precise estimation.

Table 1: Gender composition of PWDs with moderate and severe disabilities
(by type and cause of disability)

Number and distribution of disabilities and causes by gender					
Type of disability	**Total number**	**Male**		**Female**	
		Number	%	Number	%
Mobility	525,331	364,541	38.5	160,790	30.2
Hearing	136,381	82,822	8.7	53,559	10
Speech	117,389	68,527	7.2	48,862	9.2
Sight	232,624	134,047	14.1	98,577	18.5
Learning	206,351	121,028	12.8	85,323	16
Strange behavior	135,003	85,719	9.0	49,284	9.2
Other	128,205	91,393	9.6	36,812	6.9
Total*	**1,481,284**	**948,077**	**100**	**533,207**	**100**

- Total numbers add up to more than the total numbers of persons estimated with moderate to severe disabilities in the 1994-95 MoLISA survey (namely, 1,297,695), because some persons had multiple disabilities. Number of cases for which information on type of disability is reported is more than the number of cases for which cause of disability is reported.

Fig. 1: Types of PWDs in Vietnam

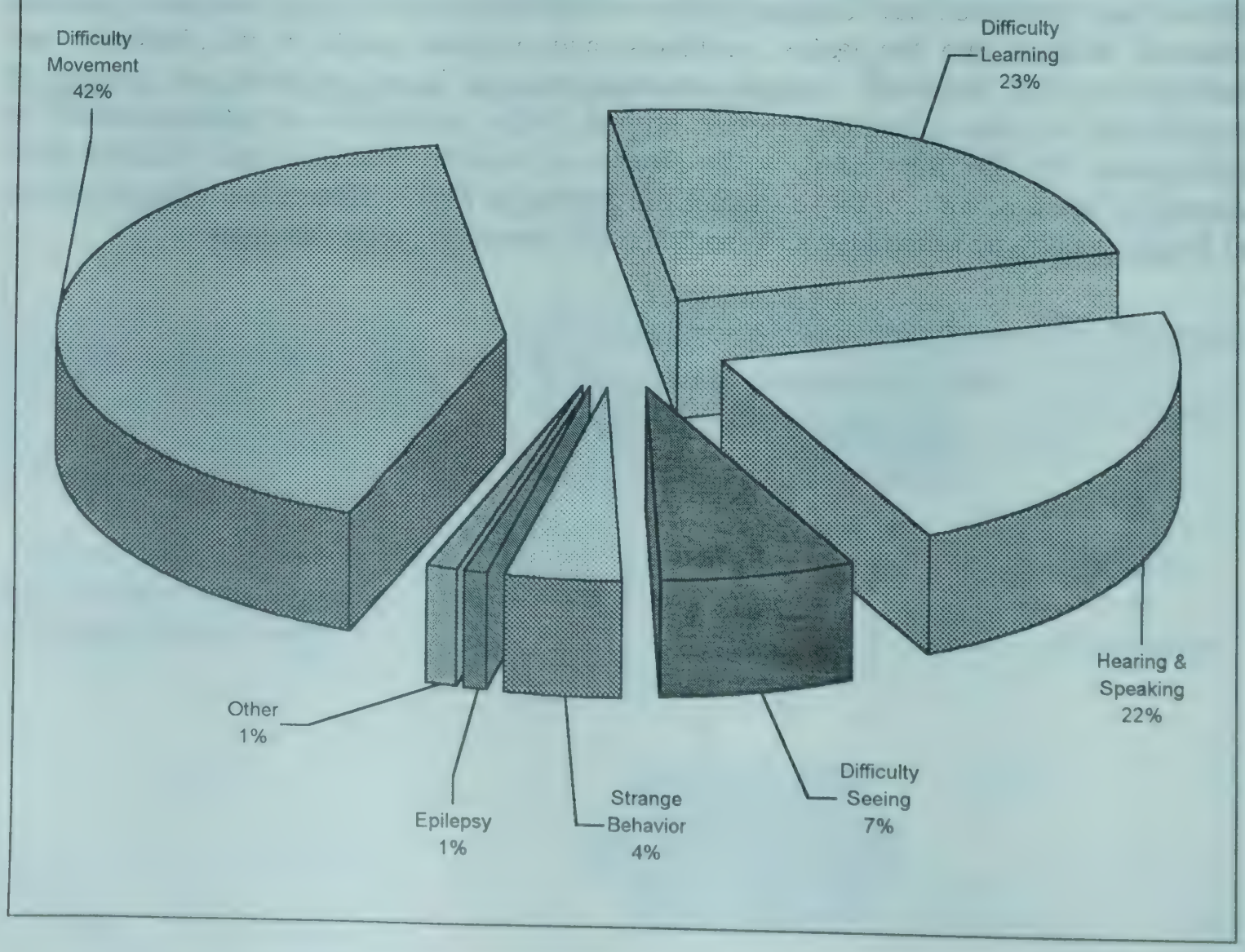
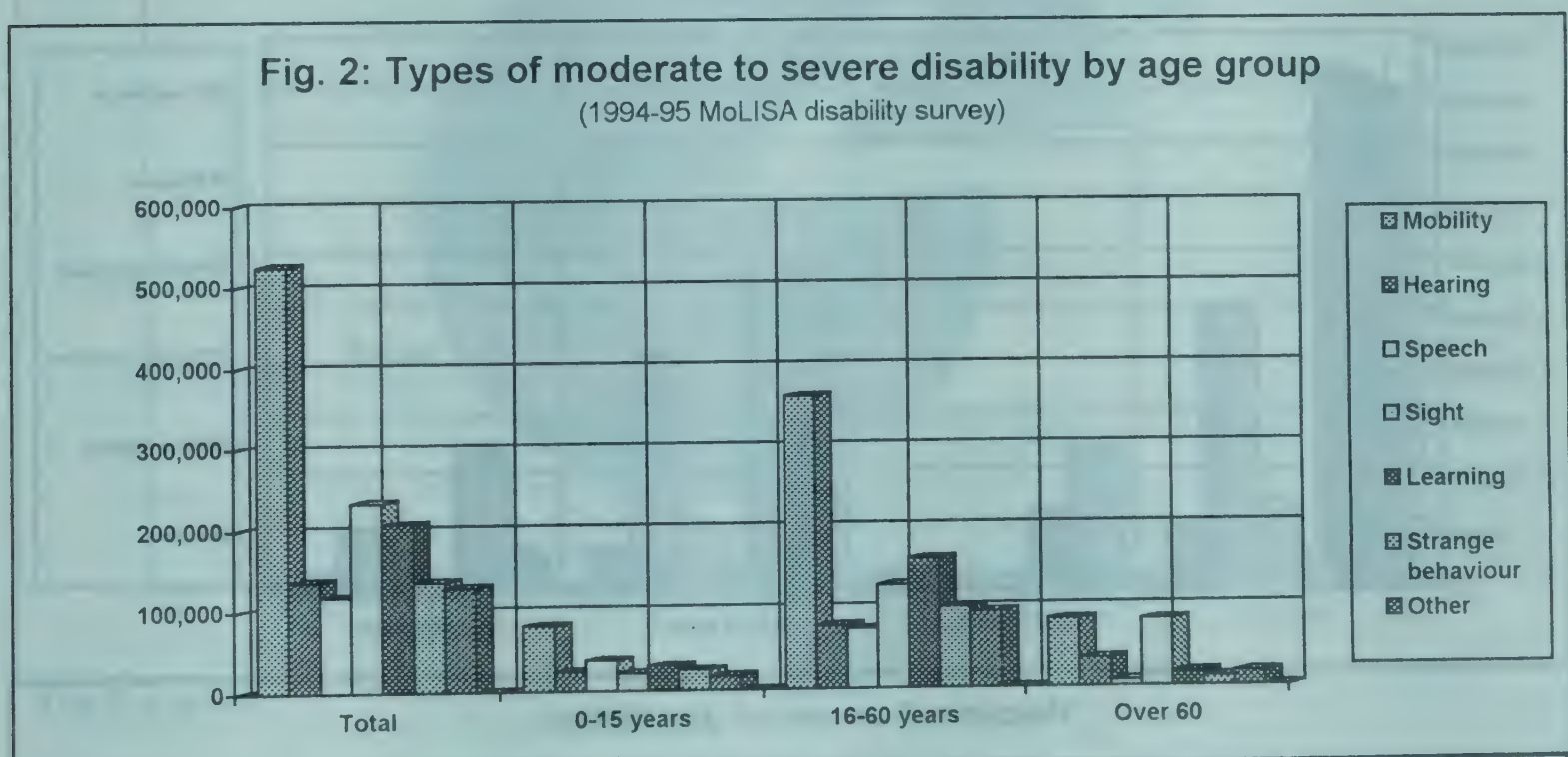


Table 2: Types of moderate to severe disabilities by age

Number and percent distribution of disabilities by age								
Type of disability	Total		Age					
			0-15		16-59		Over 60	
	Number	%	Number	%	Number	%	Number	%
Mobility	525,331	35.5	80,529	34.3	361,277	36.4	83,525	32.9
Amputees (total)	106,670	7.2	3,663	1.6	8,721	8.8	15,795	6.2
Upper limb	41,486	2.8	2,331	1.0	32,768	3.3	6,387	2.5
Lower limb	66,184	4.4	1,332	0.6	54,444	5.5	9,405	3.7
Limb deformity	183,773	12.4	26,667	11.3	131,233	13.2	25,873	10.2
Paralysis cases	151,766	10.2	34,902	14.9	88,070	8.9	28,794	11.4
Hearing	136,381	9.2	23,873	10.2	77,868	7.8	34,640	13.7
Speech	117,389	7.9	37,362	15.9	72,942	7.3	7,085	2.8
Sight	232,624	15.7	21,131	9	126,942	13	82,551	32.6
Learning	206,351	13.9	29,856	12.7	159,303	16	17,192	6.8
Strange Behavior	135,003	9.1	25,080	10.7	98,732	9.9	11,191	4.4
Other	128,205	8.6	16,998	7.2	93,836	9.4	17,371	6.8
Total	**1,481,284**	**100**	**234,289**	**100**	**992,900**	**100**	**253,555**	



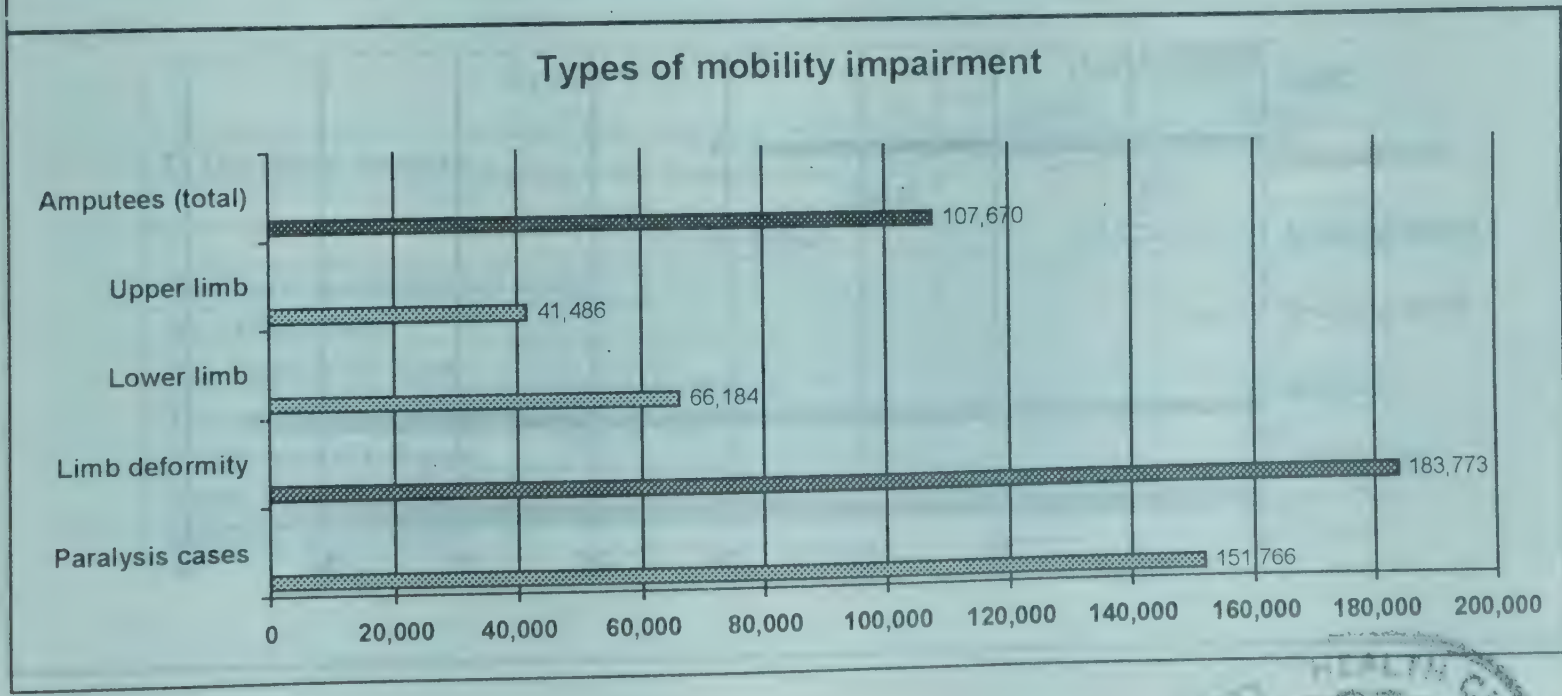


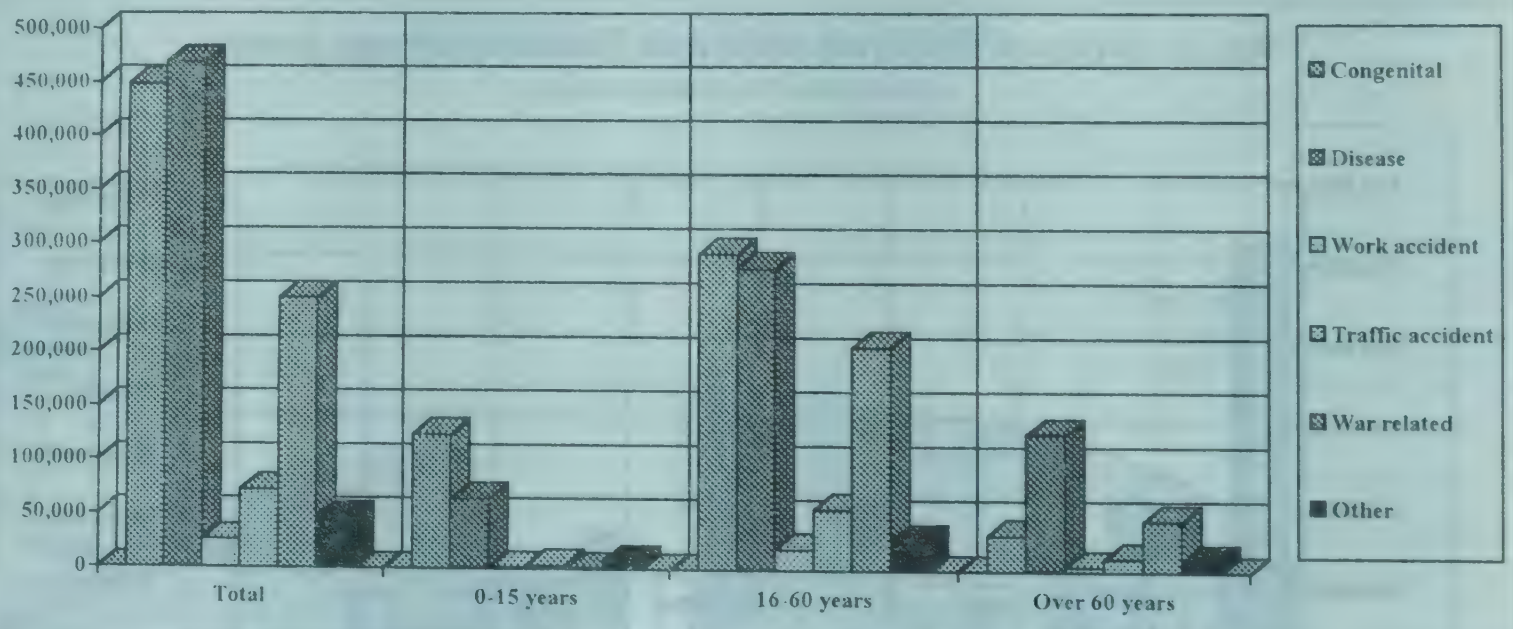
Table 3: Cause of moderate to severe disabilities by age

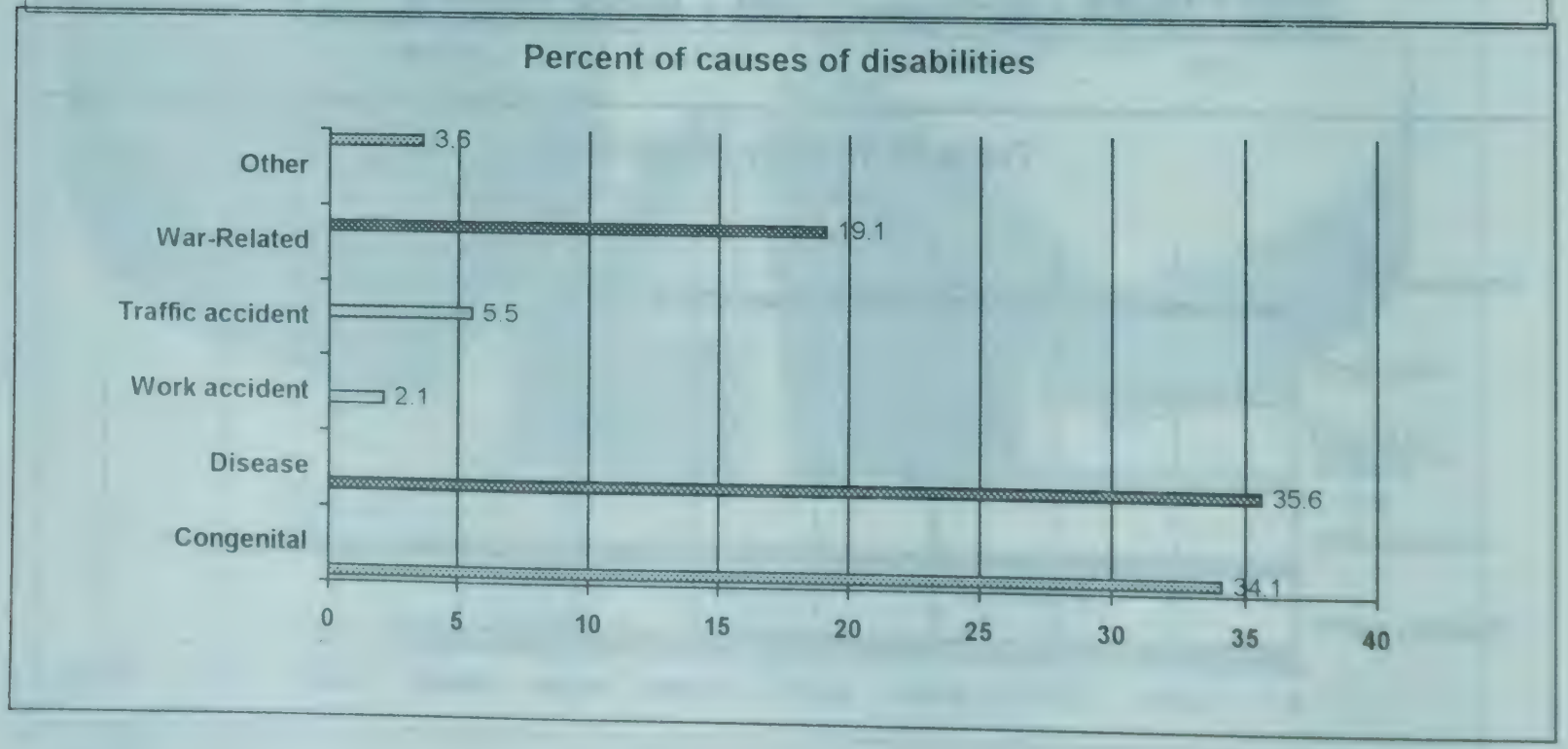
Number and percent distribution of causes of disabilities by age								
Cause of disability	Total		Age					
			0-15		16-59		Over 60	
	Number	%	Number	%	Number	%	Number	%
Congenital	44,8319	34.2	123,981	61.3	291,000	33.1	33,338	27.6
Disease	468,971	35.7	64,527	31.9	278,433	31.7	126,011	13.8
Work accident	26,010	2	1,714	0.8	19,464	2 2	4,832	6.6
Traffic accident	72,472	5.5	3,710	1.8	56,311	6.4	12,451	5.1
War-Related	250,265	19.1	945	0.5	205,719	23.4	43,601	0 5
Other	46,653	3.4	7,452	3.7	28,292	3.2	10,909	16
Total	**1,312,690**	**100**	**202,239**	**100**	**879,219**	**100**	**231,142**	

MoLISA source

Fig. 3: Cause of moderate to severe disability by age groups

(1994-95 MoLISA disability survey)

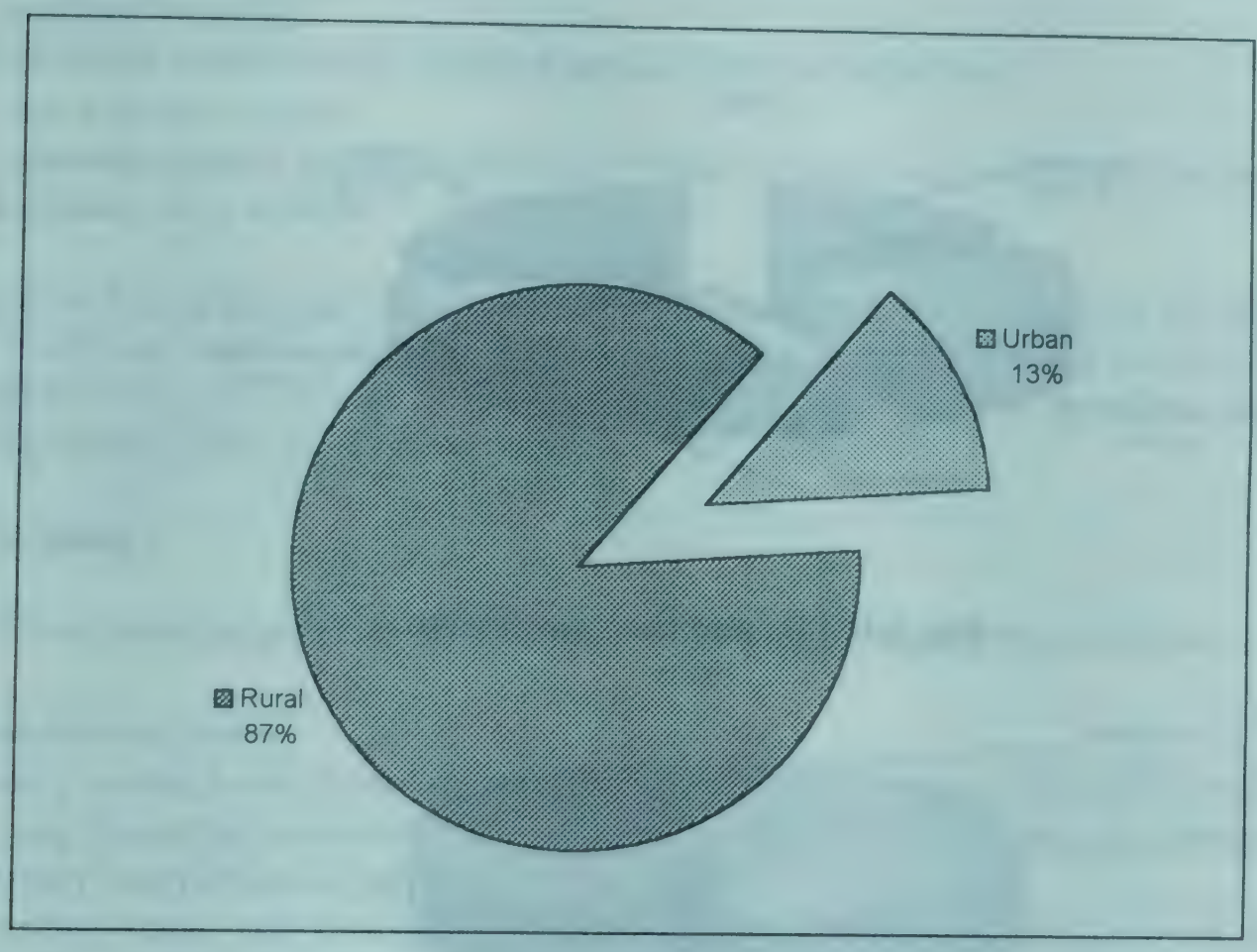




V. Some aspects of labor and jobs for PWDs in Vietnam

Introduction

The number of disabled people (not including invalids, wounded soldiers, and workers who suffered from vocational accidents) in Vietnam is estimated to be about 6% of the population. The sample survey of severe disabilities, which was conducted by the Center of Scientific Information of MoLISA in 1994-1995, revealed the following findings:

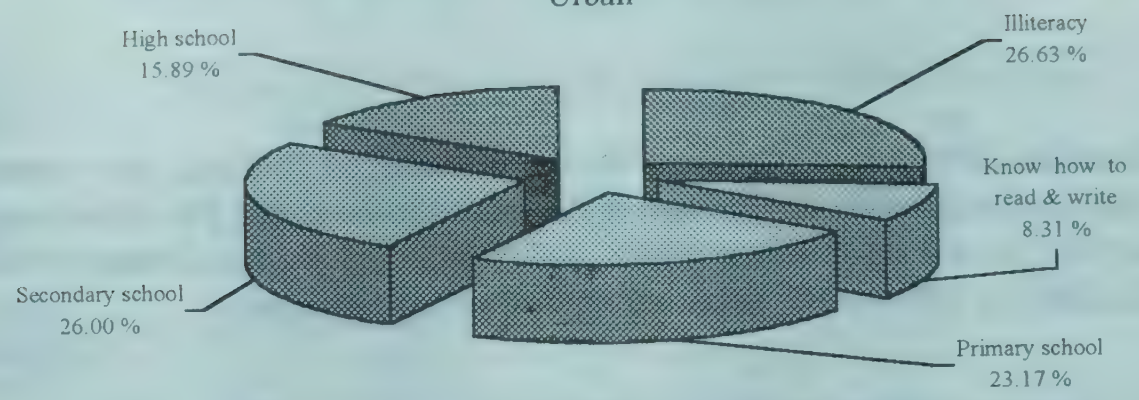


MoLISA source

Area	Percentage	
	Urban	Rural
In the whole country	12.73	87.27
Total	100	
in detail		
Northern mountainous area	10.00	90.00
Red River delta	8.99	91.01
The former IV area	4.41	95.59
The coastal central area	10.42	89.58
Western central area	14.00	86.00
South Eastern area	42.98	57.02
Mekong River delta	15.32	84.68

Fig. 5:PWDs literacy level

Urban



Rural

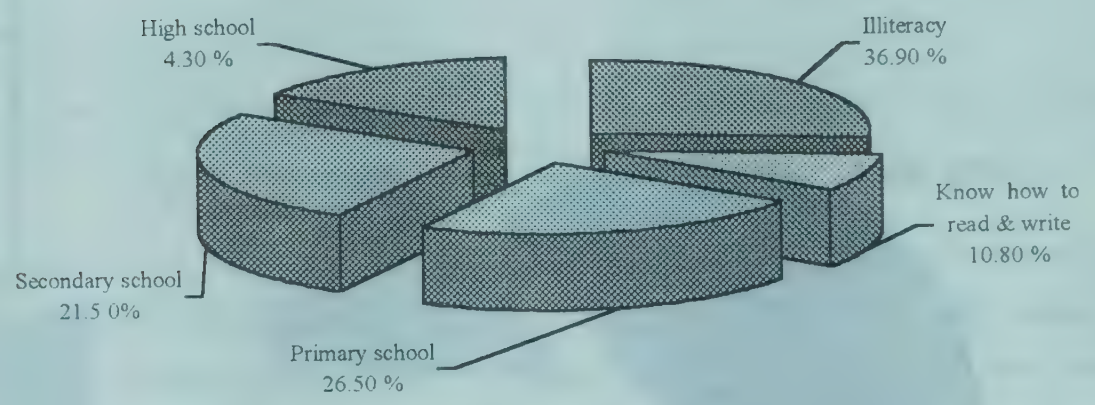
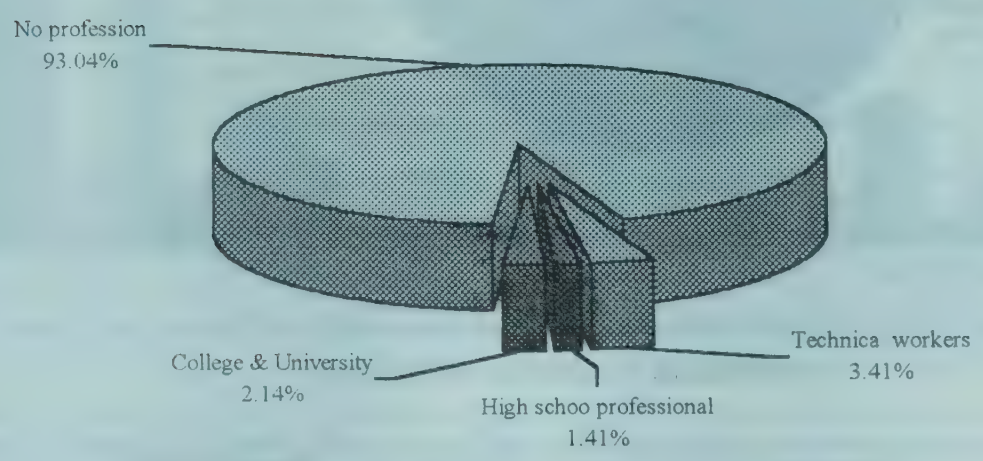
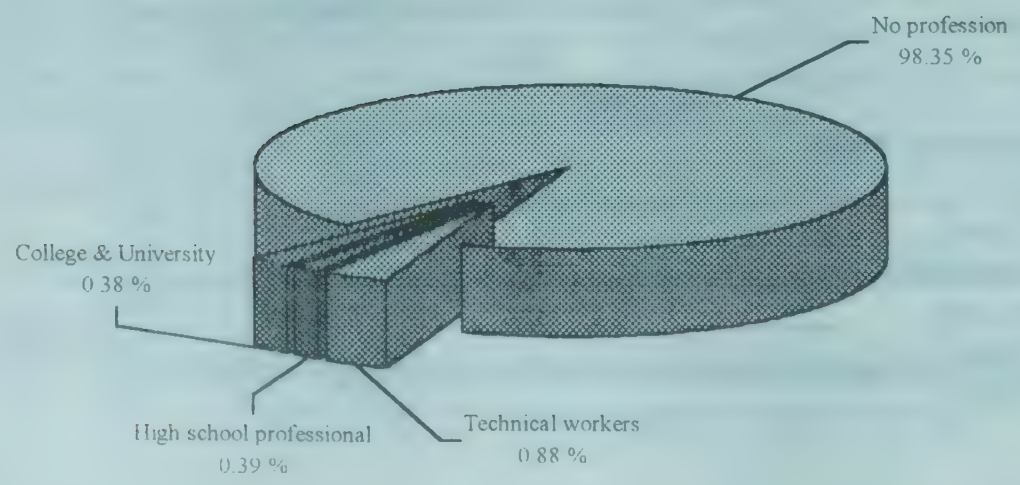


Fig. 6:PWDs and their profession

Urban



Rural



MoLISA source

Vocational Training (VT)

The Government regulations, state that there are some discounts, and social financial supports for the disabled trainees, as well as support for the training centers that give training for PWDs or special centers for PWDs. Labor Code articles 21, 125, 126 and the Disability Decree articles 18, 19 and the Governmental regulations 81/CP, 90/CP regulate in detail and guide the implementation of the Labor Code on VT and labor for PWDs, which states that the Government supports PWDs in the annual budget through expenditure on:

- vocational training;
- enterprises which employ disabled persons get a tax reduction;
- loans with low interest;
- vocational centers are supported initial infrastructure, tax exemptions, low-interest loans, and many other benefits.

In order to help PWDs in training, the training centers must comply with the regulations on labor conditions, labor equipment, appropriate hygiene and safety in the working environment and give health care checks frequently to disabled people. There have been 56 vocational training classes given for disabled persons.

Job creation

The Government supports job creation for PWDs through regulations as follows:

- low-interest loans;
- policy in which enterprises must employ a certain percentage of disabled employees;
- giving favorable conditions for special businesses for PWDs and the enterprises which employ many disabled person as well;
- working status and time work for PWDs at the enterprises are followed the decision 15/TTg (1992) of the Prime Minister, art. III of chapter XI of the Labor's Code.

The articles from 20 to 23 of the Disability Decree and the regulations 72/CP, and 81/CP of the Government regulate in detail and guide the implementation of some articles of the Labor Code, on the labor of PWDs. Article 125 of the Labor Code the regulation 81/CP of the Government regulate the enterprises of electricity, metallurgy, chemistry, geology, map survey, petroleum, mining, infrastructure construction, transportation of all economic sectors, all kinds of property must employ the PWDs as 2% of the work force. The enterprises of the other sectors must employ 3%, if the percentage of disabled employees in one enterprise does not meet this target, it has to pay some money to a job fund to help PWDs in employment (MoLISA, MoF, MoPI are combined to give a decision in which the enterprises don't employ enough disabled persons have to pay for the job's fund a minimum salary of one month). If the minimum employment of PWDs rate of an enterprise is 31%, it could get help from the Government in case of facing difficult situation the following facilitation:

- capital support;
- low-interest loans.

The household farmers which are disabled people without any relatives using land to agriculture and reforest don't have to pay taxes on using land.

Some figure[14]

Up to 1996, there have been 340 enterprises employing 12,500 disabled person and the Government supports 12.5 billion VND (around 893,000 US$), which includes 17 state enterprises the rest are cooperatives. There are 125 concentration manufactures, and the rest is based on community. There are also 27 manufacturers in which each hires 100-250 disabled people. The national fund for employment loan capital for job creation 27.2 billion VND (around 1,950,000 US$) for blind people and about 8 billion VND (around 570,000 US$) for people with other disabilities.

Vocational training situation

Vocational Training services for PWDs are not numerous. Actually, VT is still a great demand which can hardly be met, both in term of quantity and output (job availability) expected. The actual VT system consists, of two VT centers run by MoLISA, and pre-VT section in most of the existing 72 special schools. The two VT centers for PWDs are located in Son Tay province, and at Thu Duc (formerly, was a center for war invalids) in HCMC, both with a capacity for 300 enrolments each year. A new regulation by MoLISA, set the percentage of PWDs as 70% of the enrolled total. Currently, training is available for seven professions:

- Civil electronics: 24 months;
- Civil electricity: 14 months;
- Civil tailoring: 10 months;
- Industrial tailoring: 3 months;
- Office informatic: 5 months;
- Automobile mechanic: 18 months;
- Motorbike mechanic: 6 months.

The remaining problems

1. Transferring technology and technique guidance for enterprises of PWDs have not received much attention. These things help PWDs improve the quality of their products to compete in the market.
2. Jobs for PWDs still face many obstacles because their literacy level is low, most of them are poor and lack capital. Many have not been in training and need a job but are out of employment. PWDs who have job have average income equal 68% of people without disability in urban areas, and 70% of people without disability in the countryside.
3. There is no research on job for PWDs to find out what kinds of jobs and occupations are available for PWDs in the different provinces, what kinds of jobs and occupations are suitable for each kind of disabilities and which could help in training and offering jobs for them.

[14] MoLISA source

VI. Prosthetic & Orthotic production

Distribution and client service

Throughout the country, at least 23 government rehabilitation centers have P&O workshops (14 MoLISA, 3 DoLISA, 3 MoH). Moreover, 21 Leprosy Treatment Centers have physiotherapy and other rehabilitation services, a few of them have a small workshops that make some P&O devices as well. There are also, 34 hospitals within the Military Medical Service system, and some private organizations make P&O devices. The list of the main Orthopedic & Rehabilitation centers, and P&O workshops operating in Vietnam:

MINISTRY OF LABOUR, INVALIDS AND SOCIAL AFFAIRS

1. Orthopedic workshop (branch from Orthopedic/Rehabilitation Center Ba Vi), Hanoi
2. Orthopedic/Rehabilitation Center Ba Vi, Ha Tay province
3. Orthopedic/Rehabilitation Center Kien An, Hai Phong province
4. Orthopedic/Rehabilitation Center Tam Diep, Ninh Binh province
5. Orthopedic/Rehabilitation Center, Da Nang province
6. Orthopedic/Rehabilitation Center Quy Nhon, Binh Dinh province
7. Orthopedic/Rehabilitation Center, Ho Chi Minh City
8. Orthopedic/Rehabilitation Center for Handicapped Children, Ho Chi Minh City
9. Orthopedic/Rehabilitation Center, Can Tho province

MINISTRY OF HEALTH

1. Orthopedic workshop, Viet-Duc hospital, Hanoi
2. Orthopedic workshop, "Olaf Palmer" hospital (NIP), Hanoi
3. Orthopedic workshop, Bach Mai hospital, Hanoi
4. Orthopedic workshop, Dong Ha provincial hospital, Quang Tri province
5. Orthopedic workshop, Hue provincial hospital, Thua Thien Hue province
6. Orthopedic workshop, Nha Trang Rehab. Center for CWDs, Khanh Hoa province
7. Orthopedic workshop, Da Lat Peace Village, Lam Dong province
8. Orthopedic workshop, Rehabilitation Center, Vinh Long province

DEPARTMENT OF LABOUR, INVALIDS AND SOCIAL AFFAIRS

1. Orthopedic/Rehabilitation, Thai Nguyen Center for CWDs, Bac Thai province
2. Orthopedic/Rehabilitation Center, Hanoi
3. Orthopedic workshop, Quang Ninh province
4. Orthopedic workshop, Thai Binh province
5. Orthopedic workshop, Thanh Hoa province
6. Orthopedic/Rehabilitation Center Vinh, Nghe An province

OTHER WORKSHOPS:

1. Mr. Thang's orthopedic workshop, Hanoi
2. Mr. Loi's orthopedic workshop, Hanoi
3. Ba-Tru's orthopedic workshop, Ho Chi Minh City

4. Orthopedic workshops & rehabilitation center in Vietnam

MINISTRY OF LABOUR, INVALIDS AND SOCIAL AFFAIRS
DEPARTMENT OF LABOUR, INVALIDS AND SOCIAL AFFAIRS
MINISTRY OF HEALTH
OTHER WORKSHOPS

Number and rate of the PWDs needs P&O[15]

Refer to the 1994-1995 survey conducted in 21 provinces by DoLISA (population surveyed 21,039,000 persons) a total number of 107,074 (0,52% of the above surveyed population) needs P&O.

Table 4: Rate according to the different types of P&O
(compare with the whole P&O)

Prosthetic Limb	Artificial Hand	Ortheses & corset	Orthopedic shoes	Wheelchair & others
29.9%	9.5%	31.6%	18%	11%

Table 5: Percentage of the motor disabled
(in three different areas)

Disease	North	Middle	South
	%	%	%
Amputees	5.44	9.17	9.51
Hands	3	3.83	2.55
Legs	2.44	5.34	6.96
Club-foot Deformity hands & legs	15.09	14.06	11.80
Paralysis	8.84	10.38	15.11

Table 6: The results of providing P&O
(from 1991 to 1998)

Center	Total P&O	Artificial Limbs & hands	Orthoses	Orthopedic shoes	Wheelchair
Ba Vi	36,688	28,281	1,493	6,964	-
Hai Phong	3,839	2,963	112	764	-
Tam Diep	9,605	7,079	366	2,160	-
Thanh Hoa	7,551	6,063	278	1,210	-
Vinh	12,218	8,999	690	2,529	-
Da Nang	18,216	13,882	1,375	3,019	-
Quy Nhon	11,734	7,346	1,288	3,100	-
HCMC	23,724	18,117	2,575	3,035	-
Poliochildren	5,865	-	4,000	1,865	700
Can Tho	25,698	20,284	2,695	2,719	500
Thu Duc	5,725	5,743	-	-	1,500
19/12 Hanoi	8,699	6,288	1,285	1,126	-
Thai Binh	1,500	1,200	-	300	-
POC	6,662	6,662	-	-	-
BOTC	-	-	-	-	5,000
Others	7,000	2,000	4,000	1,000	-
Total	**184,855**	**134,907**	**20,157**	**29,791**	**7,700**

Production and supply of P&O

With the exception of private Prosthetic & Orthopedic workshops, the rehabilitation centers, institutes and workshops above mentioned, regularly collect data and report on P&O production and client characteristics. The different kind and number of Prosthetic & Orthopedic devices produced at prosthetic and orthopedic workshops in 1998 for amputees in Vietnam, can be noted on the following table 7:

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[15] MoLISA source

Table 7: P&O produced at orthopedic workshops

Center	Type of P&O produced and supplied in 1998								
	Above knee	Below Knee	Total arms	Total braces*	Corsets	Orthopedic shoes	Wheelchairs	Total repair	Total devices
Viet Duc Ba Vi + Hanoi center****	822	1,689	358	45	50	1,267	-	386	4,231
Ba Vi Tech. Orthopedic center	-	-	-	-	-	-	400	-	400
Kien An Haiphong	109	197	33	9	-	193	-	-	541
POC	18	324	-	-	-	-	-	-	342
19/12 Hanoi****	287	482	120	28	3	1,585	-	126	2,505
Tam Diep center	48	95	62	3	54	15	-	-	277
Ha Tinh WS**	-	40	-	-	-	-	-	-	40
Thanh Hoa center	194	471	51	29	-	255	-	-	1,000
Thuy An Children center	-	-	-	200***	-	-	-	-	200
Vinh center	398	578	146	43	-	198	-	-	1,363
Da Nang center	317	820	81	313	9	366	-	-	1,906
Qui Nhon Quy Hoa LTC	216	451	86	153	7	164	-	15	1,077
HCMC center + Thu Duc center	661	1,910	244	230	-	414	0 100	404	3,459 100
HCMC Disabled Children center	-	-	-	568	-	279	-	-	847
Can Tho center	364	1,205	22	251	8	243	-	1,306	2,093
Quang Tri WS	15	35	-	-	-	-	-	-	50
Thai Binh WS	15	35	-	-	-	-	-	-	50
Quang Ninh WS	15	35	-	-	-	-	-	-	50
Hue hospital MoH center	100	200	-	200	See Braces	50	-	-	550
NIP Hanoi	-	-	-	938	43	34	-	-	1,015
Thang Hanoi Ba Tru, HCMC	-	64 50	-	254	-	-	-	-	318 50
Le Duc Loi WS Hanoi	5	15	-	200	See Braces	-	-	-	220
Kien Tuong Co HCMC	-	-	-	-	-	-	200	-	200
Total	**3,584**	**8,696**	**1,203**	**3,464**	**174**	**5,063**	**700**	**2,297**	**22,884**

* Including all leg, arm, back, neck braces, orthoses, etc.
** Belongs to Tam Diep Center, were they make Jaipur BK limbs only.
*** Data are for 1997: Thuy An Center imports 200 devices in 1997.
**** 19/12 Hanoi Center, and Viet Duc Hanoi Center also made 694 and 1,000 crutches.

According the MoLISA estimation, on average, amputees require a new limb every three years. Using the MoLISA survey estimates of 107,000 amputees as the best estimate of current amputee estimates, annual production of approximately 35,700 limbs would be required to meet the present demand. Using this data, average annual estimate still results in the current production being less than half of the current need for prostheses (assuming that prostheses need to be replaced every three year).

MoLISA source

Table 8: Total amputees population

Province	Population (P1)	Total amputees (P2)	Total Male amputees (P3)	Total Female amputees (P4)	Total Lower Limb amputees (P5)	Total Above Knee amputees (P6)	Total Below Knee amputees (P7)	Total Upper Limb amputees (P8)	Total Above Elbow amputees (P9)	Total Below Elbow amputees (P10)	Total Children amputees (P11)	Total Children L. L. amputees (P12)	Total Children A. K. amputees (P13)	Total Children B. K. amputees (P14)	Total Children U. L. amputees (P15)	Total Children A. E. amputees (P16)	Total Children B. E. amputees (P17)
North																	
Bac Can	288,687	390	265	125	343	103	240	47	16	30	14	12	4	8	2	1	1
Bac Giang	1,507,800	2,036	1,384	651	1,791	537	1,254	244	85	159	71	63	19	44	9	3	6
Bac Ninh	1,012,380	1,367	929	437	1,203	361	842	164	57	107	48	42	13	29	6	2	4
Cao Bang	658,047	888	604	284	782	235	547	107	37	69	31	27	8	19	4	1	2
Ha Giang	586,965	792	539	254	697	209	488	95	33	62	28	24	7	17	3	1	2
Ha Nam	865,908	1,169	795	374	1,029	309	720	140	49	91	41	36	11	25	5	2	3
Ha Noi	2,477,100	3,344	2,274	1,070	2,943	883	2,060	401	140	261	117	103	31	72	14	5	9
Ha Tay	2,477,100	3,344	2,274	1,070	2,943	883	2,060	401	140	261	117	103	31	72	14	5	9
Hai Duong	1,766,280	2,384	1,621	763	2,098	630	1,469	286	100	186	83	73	22	51	10	4	7
Hai Phong	1,723,200	2,326	1,582	744	2,047	614	1,433	279	98	181	81	72	21	50	10	3	6
Hung Yen	1,184,700	1,599	1,088	512	1,407	422	985	192	67	125	56	49	15	34	7	2	4
Hoa Binh	801,288	1,082	736	346	952	286	666	130	45	84	38	33	10	23	5	2	3
Lao Cai	605,274	817	556	261	719	216	503	98	34	64	29	25	8	18	3	1	2
Lang Son	761,439	1,028	699	329	905	271	633	123	43	80	36	32	9	22	4	2	3
Lai Chau	571,887	772	525	247	679	204	476	93	32	60	27	24	7	17	3	1	2
Nam Dinh	2,046,300	2,763	1,879	884	2,431	729	1,702	332	116	215	97	85	26	60	12	4	8
Ninh Binh	952,068	1,285	874	411	1,131	339	792	154	54	100	45	40	12	28	5	2	4
Phu Tho	1,346,250	1,817	1,236	582	1,599	480	1,120	218	76	142	64	56	17	39	8	3	5
Quang Ninh	1,077,000	1,454	989	465	1,279	384	896	174	61	113	51	45	13	31	6	2	4
Son La	874,524	1,181	803	378	1,039	312	727	142	50	92	41	36	11	25	5	2	3
Thai Binh	1,938,600	2,617	1,780	837	2,303	691	1,612	314	110	204	92	81	24	56	11	4	7
Thai Nguyen	1,077,000	1,454	989	465	1,279	384	896	174	61	113	51	45	13	31	6	2	4
Tuyen Quang	707,589	955	650	306	841	252	588	115	40	75	33	29	9	21	4	1	3
Vinh Phuc	1,184,700	1,599	1,088	512	1,407	422	985	192	67	125	56	49	15	34	7	2	4
Yen Bai	722,667	976	663	312	859	258	601	117	41	76	34	30	9	21	4	1	3
Total North	**29,214,753**	**39,440**	**26,819**	**12,621**	**34,707**	**10,412**	**24,295**	**4,733**	**1,656**	**3,076**	**1,380**	**1,215**	**364**	**850**	**166**	**58**	**108**

Province	Population (P1)	Total amputees (P2)	Total Male amputees (P3)	Total Female amputees (P4)	Total Lower Limb amputees (P5)	Total Above Knee amputees (P6)	Total Below Knee amputees (P7)	Total Upper Limb amputees (P8)	Total Above Elbow amputees (P9)	Total Below Elbow amputees (P10)	Total Children amputees (P11)	Total Children L. L. amputees (P12)	Total Children A. K. amputees (P13)	Total Children B. K. amputees (P14)	Total Children U. L. amputees (P15)	Total Children A. E. amputees (P16)	Total Children B. E. amputees (P17)
Central																	
Ha Tinh	1,400,100	1,890	1,285	605	1,663	499	1,164	227	79	147	66	58	17	41	8	3	5
Nghe An	1,938,600	2,617	1,780	837	2,303	691	1,612	314	110	204	92	81	24	56	11	4	7
Quang Binh	831,444	1,122	763	359	988	296	691	135	47	88	39	35	10	24	5	2	3
Quang Tri	582,657	787	535	252	692	208	485	94	33	61	28	24	7	17	3	1	2
Thanh Hoa	1,615,500	2,181	1,483	698	1,919	576	1,343	262	92	170	76	67	20	47	9	3	6
Thua Thien	1,077,000	1,454	989	465	1,279	384	896	174	61	113	51	45	13	31	6	2	4
Total Central	**7,445,301**	**10,051**	**6,835**	**3,216**	**8,845**	**2,654**	**6,192**	**1,206**	**422**	**784**	**352**	**310**	**93**	**217**	**42**	**15**	**27**
South																	
Da Nang	712,021	961	654	308	846	254	592	115	40	75	34	30	9	21	4	1	3
Dac Lac	1,400,100	1,890	1,285	605	1,663	499	1,164	227	79	147	66	58	17	41	8	3	5
Dong Nai	2,046,300	2,763	1,879	884	2,431	729	1,702	332	116	215	97	85	26	60	12	4	8
Dong Thap	1,615,500	2,181	1,483	698	1,919	576	1,343	262	92	170	76	67	20	47	9	3	6
An Giang	2,154,000	2,908	1,977	931	2,559	768	1,791	349	122	227	102	90	27	63	12	4	8
Binh Dinh	1,507,800	2,036	1,384	651	1,791	537	1,254	244	85	159	71	63	19	44	9	3	6
Binh Duong	696,148	940	639	301	827	248	579	113	39	73	33	29	9	20	4	1	3
Binh Phuoc	572,465	773	526	247	680	204	476	93	32	60	27	24	7	17	3	1	2
Binh Thuan	991,917	1,339	911	429	1,178	354	825	161	56	104	47	41	12	29	6	2	4
Ba Ria – Vung Tau	751,746	1,015	690	325	893	268	625	122	43	79	36	31	9	22	4	1	3
Bac Lieu	831,526	1,123	763	359	988	296	691	135	47	88	39	35	10	24	5	2	3
Ben Tre	2,369,400	3,199	2,175	1,024	2,815	844	1,970	384	134	249	112	99	30	69	13	5	9
Ca Mau	1,152,390	1,556	1,058	498	1,369	411	958	187	65	121	54	48	14	34	7	2	4
Can Tho	2,046,300	2,763	1,879	884	2,431	729	1,702	332	116	215	97	85	26	60	12	4	8
Gia Lai	869,139	1,173	798	375	1,033	310	723	141	49	92	41	36	11	25	5	2	3
HCMC	5,061,900	6,834	4,647	2,187	6,014	1,804	4,209	820	287	533	239	210	63	147	29	10	19
Khanh Hoa	1,040,382	1,405	955	449	1,236	371	865	169	59	110	49	43	13	30	6	2	4
Kien Giang	1,507,800	2,036	1,384	651	1,791	537	1,254	244	85	159	71	63	19	44	9	3	6

Province	Population (P1)	Total amputees (P2)	Total Male amputees (P3)	Total Female amputees (P4)	Total Lower Limb amputees (P5)	Total Above Knee amputees (P6)	Total Below Knee amputees (P7)	Total Upper Limb amputees (P8)	Total Above Elbow amputees (P9)	Total Below Elbow amputees (P10)	Total Children amputees (P11)	Total Children L. L. amputees (P12)	Total Children A. K. amputees (P13)	Total Children B. K. amputees (P14)	Total Children U. L. amputees (P15)	Total Children A. E. amputees (P16)	Total Children B. E. amputees (P17)
South																	
Kon Tum	280,020	378	257	121	333	100	233	45	16	29	13	12	3	8	2	1	1
Lam Dong	872,370	1,178	801	377	1,036	311	725	141	49	92	41	36	11	25	5	2	3
Long An	1,400.100	1,890	1,285	605	1,663	499	1,164	227	79	147	66	58	17	41	8	3	5
Ninh Thuan	496,497	670	456	214	590	177	413	80	28	52	23	21	6	14	3	1	2
Phu Yen	800,211	1,080	735	346	951	285	665	130	45	84	38	33	10	23	5	2	3
Quang Nam	1,507,800	2,036	1,384	651	1,791	537	1,254	244	85	159	71	63	19	44	9	3	6
Quang Ngai	1,292,400	1,745	1,186	558	1,535	461	1,075	209	73	136	61	54	16	38	7	3	5
Soc Trang	1,292,400	1,745	1,186	558	1,535	461	1,075	209	73	136	61	54	16	38	7	3	5
Tay Ninh	977,916	1,320	898	422	1,162	349	813	158	55	103	46	41	12	28	6	2	4
Tien Giang	1,830,900	2,472	1,681	791	2,175	653	1,523	297	104	193	87	76	23	53	10	4	7
Tra Vinh	1,043,613	1,409	958	451	1,240	372	868	169	59	110	49	43	13	30	6	2	4
Vinh Long	1,184,700	1,599	1,088	512	1,407	422	985	192	67	125	56	49	15	34	7	2	4
Total South	**40,305,761**	**54,413**	**37,001**	**17,412**	**47,883**	**14,365**	**33,518**	**6,530**	**2,285**	**4,244**	**1,904**	**1,676**	**503**	**1,173**	**229**	**80**	**149**
Grand Total	**76,965,815**	**103,904**	**70,655**	**33,249**	**91,435**	**27,431**	**64,005**	**12,468**	**4,364**	**8,105**	**3,637**	**3,200**	**960**	**2,240**	**436**	**153**	**284**
	Provincial population	Total amputees = 0.135% of population	Total Male amputees = 68.00% of total amputees	Total Female amputees = 32.00% Of total amputees	Lower Limb amputees = 88.00% Of Total amputees	Above Knee amputees =30.00% of total L.L. Amputees	Below Knee amputees =70.00% of total L.L. amputees	Upper Limb amputees = 12.00% of total amputees	Above Elbow amputees = 35.00% of total U.L. amputees	Below Elbow amputees = 65.00% of total U.L. amputees	Total Children < 16 Apt = 3.50% of total amputees	Children Lower Limb apt = 88.00% of total children amputees	Children Above Knee apt = 30.00% of total children L.L. amputees	Children Below Knee apt = 70.00% of total children L.L. amputees	Children Upper Limb apt = 12.00% of total children amputees.	Children Above Elbow Apt = 35.00% of total children U.L. amputees	Children Below Elbow Apt = 65.00% of total children U.L. amputees

Prosthetics Outreach Foundation (P&OF, Seattle-USA) source

VII. Education in Vietnam[1]

Table 9: Classes, teachers and pupils

Kindergarten	1999-2000
Number of classes	81,100
Number of teachers	96,300
Number of pupils	2,214,100
Average number of pupils per class	27,3
Average of pupils per teacher	23
Grade schools, classes and pupils	
Schools	1999-2000
Elementary	22,199
Secondary	1,760
Classes	1999-2000
Primary	322,200
Middle	139.700
Secondary	39,900
Pupils	1999-2000
Primary	1,006,300
Middle	5,768,800
Secondary	1,974,800
Grade teachers	1999-2000
The whole country	614,800
Primary	340,900
Middle	208,800
Secondary	65,100

The education system

As late as 1945, about 90% of the population remained illiterate. This began to change with the literacy campaigns begun by the Viet Minh leadership as part of its political mass education program. After reunification, illiteracy among adults fell sharply and more children received a formal basic five-year education. In January 1979, a resolution was taken which emphasized education as an important element in the ideological revolution. The following figures[2] show the result:

- enrolment rate of primary school-aged children: 91%;
- children aged 6-15 completing primary education: 61%;
- children aged five in kindergartens: 76%;
- 360,000 children aged 6-15 are in non-formal education;
- percentage of the national budget allocated to education: 13%;
- ethnic minority children and children living in the Mekong delta are at special disadvantage because of the lack of bilingual education and schools;
- ethnic minority girls do not have the same access to school as boys because of traditional discriminatory attitudes;
- the main reasons for children to be out-of-school are poverty, the vital need work, language difficulties, inadequacy of school curricula and increasing schooling costs.

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[1] Bookyear 1999, General Statistic office source

[2] Source: Vietnam Ministry of Education and Training

The development of Special Education programs

The features of the new educational thinking of special education services in Vietnam is based on the Community-Based Rehabilitation approach, where the aims is training of local people with regular contact with children with disabilities[3]. The Community-Based approach to education was introduced in Vietnam in 1990 by giving short training courses to a number of school principals from districts earlier involved in the CBR health activities. In 1991, the staff at the NIES held the first introduction course in integration and mainstreaming. The staff at NIES had been trained on special education in the former Soviet Union during the 1970s and 1980s. No nation-wide special education services had been developed in the country, but only a few separate institutions and special schools exist, most of them in Ho Chi Minh City. When it was understood that many Vietnamese children with disabilities and other learning problems would never get access to the limited Special Education services offered, the IE approach was adopted.

Education for CWDs after CBR program implementation

The Center for Special Education, the National University Training and Development Center for Special Education, and INGOs such us: UNICEF, Save the Children/Radda Barnen Sweden, Kometee Twee, Medical Committee Netherlands Vietnam, Pearl S. Buck International, Catholic Relief Service, and Save the Children Fund/UK have been working to develop Special Education and Inclusive Education programs for children with disabilities and for some adults as well. The NIES and some NGOs have collected baseline survey data and program data to design, monitor, and evaluate the SE and IE interventions, although only limited hard data of program impact has been reported. The number of CWDs participating in these programs is still small compared to those children with disabilities in need of such education. In 1998 the MoH-MoET was reported to be working with IE in the following areas:

- number of provinces that have inclusive activities 34/61;
- districts have inclusive activities 44/601;
- number of classes, which have inclusive activities 11,000;
- number of pupils 32,000;
- number of participating teachers 10,000.

Current situation[4]

Estimates of the number of Special Education schools and Inclusive Education classes now operating and the number of disabled persons enrolled vary among sources. In fact, the HPU-TDCSE reports in 1996 a total of 104 schools for children with disabilities (of which: 54 for deaf, 14 for blind, 36 for mentally retarded). While, NIES reports that 72 schools for PWDs. Instead, a 1998 UNICEF report (by Bond and Hayter) also states that as of May 1997 a total of 72 special schools and centers (of which: 43 for hearing and speech impairments, 13 for visual impairments, and 17 for learning impairments. Moreover, it is interesting notice that two-third of those special schools being located in HCMC.) were catering to almost 4,000 children with disabilities, with more than half of these children being deaf children. Educational status and literacy rates and level among disabled persons are far lower than in the general population. The 1994-95 MoLISA Disability Survey showed that 36.9% of the total of disabled persons are illiterate, more than 97% of disabled persons do not have

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[3] Helander E., and O'Toole B., Both explain how to train personnel for CBR

[4] From Meta-Analysis of the data (Thomas T. Kane)

professional skills, and very few of them have completed a secondary school. Children with disabilities access to special schools has been limited. It has been estimated that in 1991 only 1% of children with disabilities had access to special schools, and in 1995 this figure had increased to 3%. Inclusive education for children with disabilities in mainstream schools has increasingly become the preferable alternative to meeting the educational needs of the most of the CWDs, both in terms of cost considerations and achieving social integration of CWDs in the community.

Rate: classes with CWDs = 2.1%; CWDs attend regular school = 0.36%; Teachers for CWDs = 1.6%

Fig. 7: Number of pupils, teachers, and classes
(in school year 1998-99, by province)

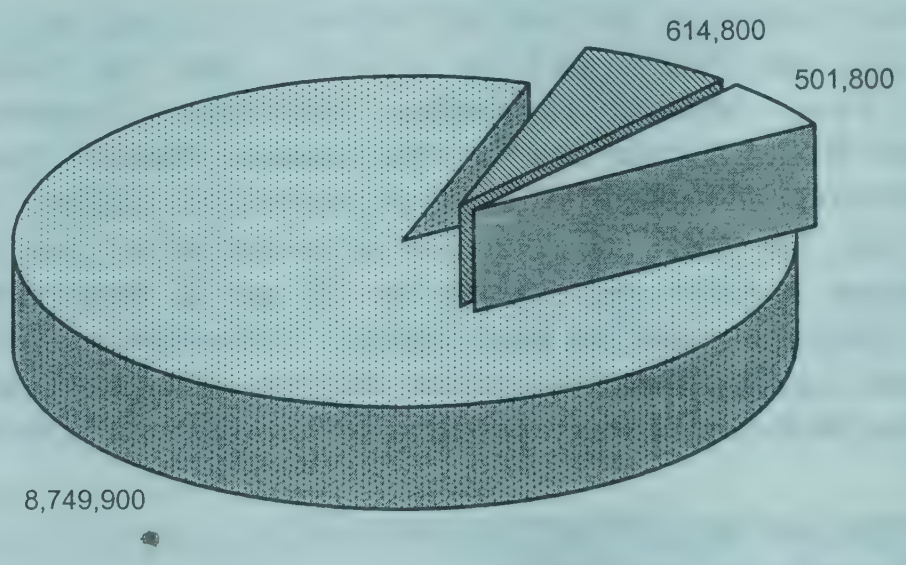
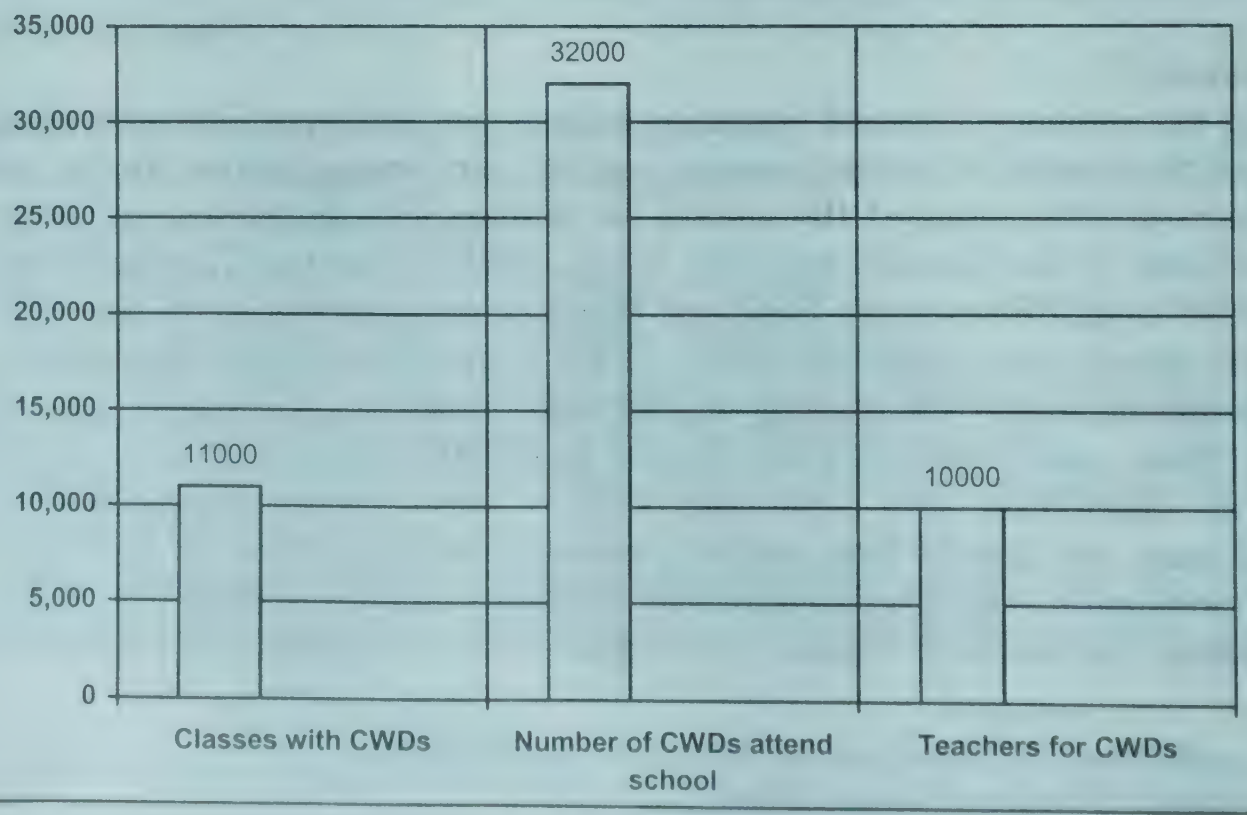


Fig. 8: Number of classes and teachers with CWDs, and number of CWDs attend regular school



VIII. Low-Income Household, PWDs included[1]

Access to credit/savings through formal, semi-formal, and informal means

Formal sector

The formal financial institutions providing services to the Low-Income Household (LIH) sector are affected by one or more of the following laws: the Law on Cooperatives, the Law on the State Bank of Vietnam, and the Law on Credit Institutions.

- Vietnam Bank Agricultural and Rural development (VBARD) has the most extensive branch network nationwide and has plans to add to the 604 inter-commune branches now in place. It is state-owned and operate as a commercial bank.
- Vietnam Bank of the Poor (VBP) was formed in 1995 for the express purpose of providing subsidized loans to poor households. They operate out of VBARD facilities and their sustainability is highly questionable.
- People's Credit Funds (PCFs) have been operating as rural credit cooperatives since 1993. They are viewed as very successful (981 operating at commune level) but are in a consolidation mode and not expanding at the moment.
- The 19 Rural Shareholding Banks (RSHBs) in rural areas (31 urban) are the outcome of the mergers and reorganization of rural credit cooperatives. Their limited service area makes them an unlikely source for serious outreach to LIH.

The semi-formal sector

The semi-formal schemes aimed at outreach to LIHs are numerous and varied. Of the various social organizations (SOs) and government programs involved in micro-finance activities, the Vietnam Women Union (VWU) and the Vietnam Farmers Union (VFU) have by far the most experience. VWU has through its own S&C schemes provided loans to 100,000 Households (HH) and assisted another 641,307 members access credit at VBARD or VBP. VFU is thought to have somewhat less in the way of numbers but still an appreciable loan outreach. A further 67,000 people have had the opportunity to borrow and/or save through the 60, or so INGO C&S schemes that have operated in Vietnam.

The informal sector

The informal realm of lending found throughout the world is a significant part of the credit scene in Vietnam. Moneylenders, family, friends, suppliers and traditional rural credit associations are the alternative sources of credit for a majority of rural HHs. It is the moneylenders who, despite their exorbitant interest rates seem to prevail in rural areas.

The Vietnam Bank Agricultural Rural Development

- Established in 1988, VBARD network grew from 463 service points in 1993 to 1,271 in 1998. It now has 527 districts branches and 604 Inter-commune branches. The ratio of Inter-commune branches/Communes is 1 for 8-15 communes on average;

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[1] Outreach diagnostic report (Vietnam-Canada rural finance outreach project)

- VBARD has switched from lending mainly to State Owned Enterprises (SOE) in 1998 to lending mainly to HHs in 1995. In 1998 loans are 30% to SOEs and 70% to HHs;
- VBARD operates with capped lending interest rates of 1.2% per month (14.4% per year) and a maximum gross margin of 0.35% per month (4.2% per year);
- 4,000,000 rural HHs customers;
- Outstanding loan average: 4,100,000 VND (around 290 USD);
- VBARD has provided loans to 33% of rural HHs, and to 27% of rural LIHs;
- VBARD has provided loans corresponding to approximately ½ of amounts requested thereby satisfying approximately 15% of LIHs demand for loan;
- 75% of all loans are for terms under 12 months;
- VBARD loans are based on a 70-80%/asset value ratio (sometimes as low as 20-50%);
- Assets owned by the potential borrowers is a most decisive criterion for lending;
- Land is the most commonly accepted form of asset/collateral.

VBARD staff

- Total staff of 21,017 of which 60% are women;
- Credit staff of 6,050 or 29% of total staff. This ratio has declined from 41% in 1993 to 29% in 1998. 34% of credit staff are women;
- Staff education level has been increasing over the years:

- University:	23% in 1993	to	45% in 1997
- High School:	50% in 1993	to	45% in 1997
- Primary School:	27% in 1993	to	10% in 1997

VBARD savings mobilization

- VBARD's sources of funds have changed rapidly from depending on external borrowing to mobilized funds. In 1993 VBARD's external borrowing represented 43% of its source of funds compared with 13% in 1997;
- Public savings mobilization grew at an annual rate of 50 to 60% over the last 4 years;
- 64% total VBARD savings mobilized are in deposits of over 10 million VND;
- 77% total VBARD savings mobilized are in deposits of over 5 million VND;
- 88% total VBARD savings mobilized are in deposits of over 3 million VND;
- average deposit size in 9 provinces surveyed was 10.3 million VND;
- 75% of public savings mobilized are short term (less than 12 months);
- 2 savings products available at grassroots level:

  - term deposits of 3-6-9-12-24, and >24 month deposits;
  - demand deposits.

Other facts

- Moneylenders charge interest rates of 5 to 10% per month;
- Approximately 31% of HHs have received Land Use Certificates (LUC);
- Female land title holders = 1/3 the number of men holding LUC;
- Female headed HHs received 20% of total loans approved for rural HHs;

- VWU has reached 100,000 HHs in their S&C programs with average loans of 500,000 VND (around 36 USD) for a total of 50 billion VND (3.8 million USD);
- Up to April 1997, 641,307 members of VWU received loans from VBARD or VBP.

Different form of financial institution in Vietnam

A. Formal rural financial institutions

VBARD

- VBARD is foremost in the formal rural financial service sector. It provides over 75% on the credit extended by formal financial institutions to rural households. The VBARD branch network generally extends to the district level, but goes to the commune level in highly populated areas. In the past few years, VBARD has introduced a number of innovations to extend its outreach.
- In 1995, VBARD started a program of poverty-oriented lending, drawing from the government's Preferential Credit Fund. At the end of 1995, the fund was transferred to VBP.
- The joint liability groups system is used to facilitate the management of loans. VBARD also works with SOs, especially the VWU and the VFU, to establish credit groups similar to the Joint Liability Groups (JLG). As well the bank works directly with the communes' HEPR Steering Committee to form JLGs. In 1997, roughly 4 million HHs accounting for 30-40% of rural HHs accessed VBARD loans. To date, VBARD has been the largest provider of financial services to LIH.
- VBARD is re-organizing its structure and notably the Credit Department for HHs and Cooperatives has been set up. The departments responsibilities are to built regulations, guidelines and models to outreach to rural HHs and cooperatives.

VBP

- VBP was formed in 1995. Its major responsibility is to provide loans to poor HHs and promote the poverty alleviation programs. The VBP is institutionally "merged" with VBARD, except for Headquarters it has no separate staff and relies entirely on the VBARD branch network to carry out its functions. The VBP plan for 1997-2000 aims to extend loans to 80% of all poor HHs. By 1998, it has provided credit to approximately 1.3 million rural poor HHs.
- The Bank is not financially sustainable as it provides credit at a subsidized rate.

PCFs

- PCFs were established as commune-based savings and credit cooperatives modeled as a Caisse Populaire.
- The development of the PCFs has been supported by the Canadian bilateral aid program through Development International Desjardins.
- The PCFs model is a credit institution operating under the Cooperative Law, made-up of members who participate in the scheme by purchasing low value shares at 50,000 VND (around 3.5 USD).

- So far, there have been 981 PCFs operational at the commune level in 51 provinces with 630,000 members. On average PCFs have a penetration rate of about 5% of the HHs at commune level. The average loan size is 4,200,000 VND (around 300 USD).
- The operational model of the PCFs is to mobilize people's capital and in turn lend it to other members. Lending and deposit procedures are simple and appropriate to the low education level of the rural population. Moreover, the diversification of credit and savings products has brought about a wide range of options to HHs that have different levels of income. PCFs' mobilization has amounted to 400 billion VND (around 285 million USD) of which 154 billion VND (around 111 million USD) is refundable membership. PCFs are in closer proximity to villagers at grassroots level when comparing than those of VBARD. Deposit insurance is available. This makes borrowers and depositors confident about doing business with PCFs, and enables PCFs to expand their rural financial services.

RSHBs

- In 1998, there were 50 shareholding banks (31 urban and 19 rural) in Vietnam. Most RSHBs were the outcome of the reorganization or merger of rural credit cooperatives.
- Only some RSHBs have lent to the poor and these were through the VWU. The Union organizes women into groups to enable them to obtain loans from RSHBs.
- RSHBs are very cautious about expanding their lending to the poor, and therefore very doubtful in terms of effort to outreach to this sector.
- The RSHBs studies showed the advantages that they had in delivering rural credit. Lending procedures are simple and staff rely on their knowledge of and close relationships with borrowers, who are sometimes relatives or friends. It is also the staff who help the applicant complete the required documents. The reliability and low cost of this processing are brought about by the dual roles of most staff, a technical personnel and shareholder. Another factor is the proximity of households. The bank's limited service area consists of a few communes where the shareholders are residents. However, the limited service area hampers any increase in shareholders, deposits and borrowings. Borrowers prefer the RSHBs to other commercial banks because of the farmers' accessibility and the institution's fast, simple processing. However, all the RSHBs can not outreach to LIH due to their limited capacity to mobilize funds.

Formal sector outreach

Institution	Outreach to rural HHs		Outreach to rural LIHs	
VBARD	4,000,000	33%	1,800,000	27%
VBP	1,300,000	11%	600,000	9%
PCF	600,000	5%	300,000	4%
RSHB	10,000	0.08%	N/A	-
Total	**5,910,000**	**49%**	**2,700,000**	**40%**

Market share of rural HH borrowers

VBARD: 4,000,000/5,910,000 = 68%, VBP: 1,300,000/5,910,000 = 22 %,
PCF: 600,000/5,910,000 = 10%, RSHB: 10,000/5,910,000 = 0.17%

Access to credit by rural HHs

- Despite the fact that a great effort has been made by formal financial institutions to meet the demand for credit, 51% of HHs remain unable to access this banking service. Many

are forced to obtain funds from the informal sector; which includes moneylenders who charge a high rate of interest;

- It is estimated that there are 6.7 million LIHs in Vietnam, 26.8% of which (1.8 million) have access to VBARD. A further 16% borrows from VBP (9%), PCFs (4%), RSHBs (0.08%), or credit programs implemented by SOs (3%). The rest seek funds from informal sources (e.g., private moneylenders, relatives and friends).

Rural financial policy

- The main Government policy relating to micro-finance and poverty alleviation includes the program for Hunger Eradication and Poverty Reduction (HEPR), that aims to reduce poverty to 10% of the population by 2000 (it is already past).
- The credit component is considered to be one of the most important elements in the HEPR program. However, the Government has not issued any policy specifically on micro-finance.
- The policy of providing subsidized credit through government programs undermines S&C scheme of NGO's, SOs, and banking services in rural areas.

B. Semi-formal rural financial sector

Social organizations

SOs are quasi-governmental bodies, which retain close links to the government and are usually represented at four administrative levels: national, provincial, district, and commune. Many organizations as VWU, VFU, Veterans Association assist in the disbursement of loans under specific Government programs. Although their mission is not to provide C&S services but rather to act as social mobilization agents. Despite their organizational strengths SOs remain weak in financial management skills as they relate to community development for economic purposes.

International Non-Governmental Organizations

INGOs S&C schemes encompass around 60 projects. Total loan funds amount to USD 2.1 million reaching more than 67,000 people. The variety of international NGOs schemes is reflected in their diverse objectives. Some are exclusively concerned with S&C. For others S&C activities are an entry point to communities to promote programs on health or family planning. Often S&C is seen as a means to promote income generation. The S&C programs of international NGOs in Vietnam indicates that they are effective at providing financial services to the poor. High loan repayment rates are reported, and successes have been achieved in savings mobilizations. However, these schemes are considered small in scope and nor sustainable in the long term as they rely on donors to cover costs.

C. Informal micro-finance

Despite the efforts to improve credit provision to rural areas, the formal financial sector can not meet rural HHs' demands for loans, leaving a large berth for the informal credit market to operate. Private moneylenders seem to dominate the provision of capital to rural areas.

Social Organizations

SOs in Vietnam consist of VWU, Youth Union, VFU, Vietnam Federation of Labor, and VFF. They emerged during the early liberation period (the 1930) to motivate the public to struggle for peace. In other words, these organizations were formed with a political motive. Recently some in particular VWU and VFU have incorporated S&C activities.

VWU

The VWU was established in 1930 as a social organization representing women of all social strata. The Union aims to protect the legitimate and legal rights and interest of women and to create conditions for women to realize equality and to participate in development. Every five years a national Congress of the VWU is held and attended by representatives of women throughout Vietnam. The congress elects a central Executive Committee of 99 members, made up of representatives of each provinces as well as representatives from the government, and other organizations such as the Trade Union, and the Youth Union. This Committee, in turn, elects the VWU Presidium of 15 members, which exercises executive power. The central office in Hanoi is divided into nine departments with a total of 232 staff. The department associated with the Outreach Project is the department of Family and Life (F&L) which has different divisions. F&L includes the division for S&C. At provincial level, a provincial Women's Congress elects a Provincial Executive Committee, which oversees the VWU program in the province, while program implementation is carried out by the president, two vice-president, and the staff of the Provincial Women's Union (PWU). The PWU office generally has a staff of about 20 (full and part-time employees). The office directs field operations through its district level office. The same structure prevails at the district level, but the total staff amounts to about five. The Commune Women's Union (CWU) has a staff of three. At all levels, VWU works closely with the local People Committee to ensure that its programs fits the broader activities of that committee. The VWU is a mass membership organization of about 11 million women, and the membership is increasing with a 3% a year. VWU has a nationwide network from the central down to grassroots level of the hamlet and village. This organizational structure enables VWU to reach the poorest people in Vietnam. This is why many INGOs choose VWU to partner in their development programs. One of its great strengths is closeness to the people at the grassroots level, because staff are reaching a large membership in rural areas.

Operations

Like other organizations in Vietnam, VWU is also under pressure to initiate changes to comply with the shift to a market economy. The government budget allocation to them is just enough to pay basic salaries for their staff. In fact, present activities now largely exist thanks to development programs funded by international NGOs and others. VWU have expanded their programs in recent years. Development activities are now considered a strategy for operations and sustainability. A recent report by VWU shows that it has cooperated with more than 30 NGOs and other international organizations such as FAO, UNFPA, UNIFEM in implementing development programs with a S&C component. The key role of VWU in cooperating with outside organizations is to implement programs utilizing financial and technical assistance. Like other social organizations, VWU have no mandate to provide credit services, however, since the lunch of "Doi Moi", credit provision has been considered as a

complementary activity. That is why, they cooperate actively with VARD and VBP banks. The main goal of VWU is to improve social and economic status of their members.

Savings and credit activities of VWU

To achieve their objectives, most programs of VWU have credit and savings components. Their C&S activities are categorized into two groups:

1. serving as a group organizers and loan guarantors for VBARD and VBP.
2. managing their own funds that come from members' savings and grant from donors.

Linking with banks

Although a formal cooperation plan at the central level between VBARD/VBP and VWU has not been finalized, at some provincial levels they have cooperated in credit operations since 1991. The cooperation process between VBARD/VBP and VWU is as follows:

- CWU set up women' group (10-12 members). Group activities include collecting principal savings, compulsory & voluntary savings; requesting DWU for support.
- Group leader contacts VWU extension officer in charge of the commune to request loans, that provides training to the group leaders and helps them fill in the loan application.
- Group leader finalizes documents to send to VBARD/VBP, that include: decision on group formation, operations regulations, minutes of group meeting, decision by the DWU, list of the members, loan application and contract to each member and group, authorization letter.
- Group leader receives the loan proceeds and disburses to group member in the presence of the bank credit officer.
- Group leader collects interest and remits to the bank on a monthly basis.
- At maturity, the leader collects the loan principal to repay to the bank.

For the time being, the VWU continues to regard the link with VBARD as an important link for its member and affords a wider and more convenient access to formal credit. The VWU has drafted a "*Joint agreement between the VWU and VBARD*" for the purpose of shoring up the link between the two in C&S activities. As of April 1997, VWU had inter-mediated 437.2 billion VND worth of loans to approximately one million members.

VWU' source of funds

Source	Loan amount (million VND)	Cumulative loan A/Cs	Number of borrowers (HHs)
VBARD	394,108	548,567	825,918
VBP	43,089	136,007	168,199
Total	**437,206**	**684,574**	**994,117**

Source: Annual reports of VWU

The ability of VWU to produce a larger number of S&C groups is affected by a lack of funds. DWU staff salaries and travel expenses must be met out of the 25% allocation of VWU membership fees, which barely covers basic office and administrative expenses. Consequently, VWU needs to charge members for the use of services such as family planning. VWU at the district level has no vehicles, essential to get to remote areas. Even at the provincial level, VWU is dependent on the use of private vehicles.

Strengths and weaknesses of VWU in S&C operations

Type/ Program	Strengths	Weaknesses
Linking with banks	- Can work according to comparative advantage- organizing, retailing money, while bank performs banking function.	- Organization garners little direct benefit from work (except sometimes, a small amount of interest income). Organization does not own program.
	- Cheaper cost structure, do not need many managers.	- Little incentive to control costs, as organization derives little direct benefit from activity.
	- Simple record keeping system.	- None.
	- Expansion of coverage without large increase in management capabilities/structure	- Organizations may not have much incentive to expand operations.
	- SOs can offer a moral guarantee to the bank, allowing for only rudimentary group formation activities.	- Organizations can be held responsible for unpaid loans.
	- Integration with formal financial system.	- Does not promote competition in rural financial services (except for formal-informal sector competition).
	- Organizations can reach the poor, a market that VBARD/VBP can not reach directly.	- Organizations also have difficulty-reaching poor. Financial instrument may have to be designed with poor in mind.
Own S&C schemes	- Local control of funds.	- Liquidity risks, depending on size of reserve fund.
	- Strong incentive to control costs.	- Higher cost incurred, more managers needed.
	- Strong incentive to charge sustainable interest rates	- Interest rates must be higher to cover increased administration costs.
	- Strong incentive to mobilize savings.	- Savings not as secure as would be the case in formal banking system. There is no legal framework to protect savers. Saving mobilization is neither legal nor illegal.
	- Strong incentive to expand coverage.	- Expanding coverage results in increasingly complex management structure.
	- Promotes competition in rural financial services.	- Legal status is unclear.

Human resources

VWU has had intensive training on group mobilization through participation in UNFPA and UNICEF projects. While much of this training was related to family planning, it was still relevant to the sensitization of S&C groups. Staff traveled to Bangladesh, Indonesia, and Philippines to observe and receive training in credit. Further training related to the use of groups has also been provided by a number of other donors such as SIDA, Grameen Bank, Cashpoor, International Cooperation for Development and Solidarity (CIDSE), and CRS.

Micro-finance services of SOs

- In a S&C projects, the prime interest of a SOs is the economic improvement of its members, that not only serves this interest but also acts as a catalyst support of other activities. Mainly, there are two approaches in credit activities of SOs:

  a. SOs own and manage members' savings and grants from donors such as INGOs.
  b. SOs serve as facilitators for the VBARD, and VBP.

Credit activities of Sos

Organization	Number of Credit groups	Borrowers	Credit sources (in USD million and in %)			
			Total	Savings	Grant	VBARD & VBP
VWU	82,032	803,534	115	8%	24%	68%
VFU	67,117	597,670	94	11%	-	89%
VYU	1,685	54,333	0,1	-	-	100%
Others	9,536	207,293	11	-	-	-
Total	**157,000**	**1,622,089**	**220.1**	**-**	**-**	

Source: Mr. Nguyen Xuan Nguyen and Stefan Nachuk (1998)

The credit service offered by SOs is highly appreciated for various reasons of which:

a. It can be channeled directly to targeted beneficiaries at the grassroots level, especially LIHs, poor women, and so on;
b. It is community-based so it has more direct and closer contact with rural customers than formal credit institution;
c. SOs often make small loans more efficiently and have higher repayment rates, mobilize local savings with flexible and simple savings schemes;
d. It improve the participation of the people at grassroots level in social activities and ensures their voices are heard.

International NGOs-rural micro-finance schemes

At the moment approximately 60 S&C projects are supported by INGOs, 28 were reviewed for the study, nine in-depth. Inspite of differences in scope (fund size), coverage (regional) and objective (targeted beneficiaries), most INGOs consider that provision of credit to the poor is critical to improve their living conditions. Poor women, ethnic minority poor, the poor in rural remote areas, and people in needs in general such as PWDs, street children etc. are the focused beneficiaries of these rural small S&C schemes. Credit schemes supported by donors amount to an aggregate USD 2.1 million, making loans to an estimated 67,000 beneficiaries in rural areas[2]. Major advantages of many INGO's S&C schemes include:

a. Their outreach to rural communities is greater than that of formal credit institutions, as they focus directly on the grassroots level. This approach helps them to avoid many administrative and bureaucratic procedures;
b. They target customers move precisely than formal credit schemes. Beneficiaries are usually poor women, poor ethnic minority groups, poor young mothers, or PWDs;
c. They help to promote the participation of local people/beneficiaries in the operation of small S&C groups;
d. Local savings mobilization is considered an important factor to ensure the sustainability of rural S&C schemes. Savings in combination with credit re-enforces the sense of responsibility of borrowers. This also helps to prove that even the poor are able to save, and that pooled small savings can become appreciable amounts;
e. A market approach to interest rates has been applied in S&C schemes. This is an important step towards building sustainable rural small S&C schemes;
f. They have flexible systems of savings, credit provision and repayment. The bulk of operations take place at grassroots level. Small savings or small repayments on a weekly/monthly basis are suitable and within the capacity of LIH;
g. Most S&C schemes have provided training to beneficiaries and local mass organizations. This has improved local capacity in credit management, and contributes to sustaining S&C group operations;
h. A guarantee fund or savings account at VBARD or VBP, and the fact of risk sharing has encouraged the banks to outreach to target beneficiaries at grassroots level.

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[2] Micro-finance in Vietnam UNDP, Hanoi 1996

Limitations include

a. Most S&C schemes have extremely limited coverage. Their operations are within the targeted communes' boundary;
b. Having no legal status, they are not institutionally sustainable;
c. Most small S&C schemes have no official linkage with formal credit institutions;
d. Most local extension workers are not working for S&C schemes on a full time basis. Accordingly, they do not try their best to improve credit activity (e.g., group meetings, monthly savings, timely repayment). Some have even given up the position assigned under the scheme when offered better job opportunities;
e. Post-lending appraisal and study are not conducted. It is time consuming for a local manager to master banking skills (e.g., training, practice, work, and so on) which are necessary to maintain grassroots S&C operations. They are often deciding on loans to beneficiaries after participating in a short-term training course. Learning on-the-job does not seem to be an appropriate approach to improve rural S&C schemes.

Strengths and weaknesses of formal financial institutions

Organization	Strengths	Weaknesses
VBARD	- Largest network to provide credit service in rural areas; - Willingness to improve outreach by following collateral free group lending up to a ceiling of VND 5 million, inter-commune transactions offices and mobile banking operations.	- Unofficial fees raise the cost of borrowing for clients; - Willingness to improve outreach comes from government rather than from VBARD's strategy; - Not targeting rural LIH; - Many rural areas still not covered; - Mixed commercial credit with government subsidized programs.
VBP	- Focus lending to the rural poor; - Impressive outreach achieved in a short time; - Good relationship with local government.	- Subsidized credit; - No financial sustainability; - Deeply depend on VBARD (staff, offices).
PCFs	- Market approach credit service; - Owned by its members; - Focus on local savings mobilization; - Commune-based credit service.	- Most loans are short-term; - Initial growth is focused on richer areas and richer clients.

Strengths and weaknesses of informal financial schemes

Organization	Strengths	Weaknesses
Semi-formal		
Social Organizations	- Large national networks reaching to the commune and village levels; - Have tried different micro-finance schemes; - Willingness and eager to mass mobilization through credit service; - Loan repayment is higher than other formal credit schemes; - Focus on poor members.	- No function of credit provision; - No institutional sustainability in term of financial service; - Lack of skills and staff for large-scale intervention in S&C; - Insufficient understanding of financial sustainability of credit schemes; - Depending on outside support.
International NGOs	- Effective in reaching the poor; - Target customers are clearly identified; - Market approach; - Have good experience and knowledge of micro-finance schemes; - Appropriate technical assistance; - Focus on sustainability and self-management of grassroots poor.	- High operating cost; - Isolated and small coverage; - Low financial fund. Dependents on concessional funds; - Due to small scope, can not reach sustainability
Informal		
Informal financial system	- Convenient, simple and local; - Market interest approach; - Lender and borrowers know each other well; - Good local saving mobilization; - Independent operating	- High cost to the poor; - Very poor are excluded; - Loan in kind at high interest rate; - Most loans are small and short-term; - Isolated operation; - Are not encouraged to become formal credit organization

IX. Impact of CBR program in Vietnam

Some important impacts

National impact on PHC[3]

- CBR checks up and stimulates other PHC programs such us Expanded Program Immunization, and Family planning;
- fully integrated in PHC system: most of CBR workers and intermediate level workers belong to primary health existing network in coordination with horizontal and vertical programs (e.g., Nutrition, EPI, Leprosy Elimination, and Mental illness);
- involvement of whole system of health services and referral system (communal health station, district, province and central levels).

Impact on development rehabilitation system

On training manpower and strategy the most important achievements from the CBR program have been:

- the adoption of new curriculum for training rehabilitation technicians (formerly called physiotherapist) in three National schools: Hai Duong, Danang and HCMC;
- new curriculum in training rehabilitation oriented mainly on CBR in Medical Colleges as: Hanoi, Hue, HCMC;
- 54 mid-medical schools at 54 provinces;
- 10,000 CBR workers trained; three Dr. Ph.D. with the research related to CBR, 70 first level doctors specialized in rehabilitation medicine, and five second level specialists, five doctors, two professors, five postgraduate students, and 55 physiotherapists. Moreover, 20 doctors are being trained to be specialists in rehabilitation;

In addition, thanks to CBR program the referral system is developed as follows:

- communal health stations have been upgraded with basic equipment for better work of assistant doctor mainly for prevention of disabilities;
- 25 rehabilitation department at district level with CBR have been set up and equipped with fundamental rehabilitation equipment (most locally made);
- 12 provincial rehabilitation departments have been established;
- two out of three rehabilitation schools have been repaired to train rehabilitation technicians;
- rehabilitation departments such as "Olaf Palmer", and Bach Mai hospitals in Hanoi, have become coordinating and training resource centers for CBR in whole country;
- with financial support from international NGOs[4], it has been issued and delivered nationwide the following teaching and information materials, translated in Vietnamese:

  - WHO Manual "TCPD";
  - Disabled Village Children, by David Werner;

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[3] MoH source

[4] Appendix: C

- CBR guide used for teaching and management;
- many other text books have been printed in joint cooperation with other centers.

Facilitating other CBR projects through

- video tapes made by Vietnamese TV on CBR shown on Vietnam television;
- radio and major newspapers took active part in increasing public awareness towards disabled persons;
- the National Steering Committee for CBR merged into the Vietnam Association of Rehabilitation (VINAREHA) founded in March 1991 with the main objective and strategy to develop CBR in the country.

International

- CBR experiences of Vietnam have been shared in some regional and international seminars, conferences and congresses (e.g., Italy, Indonesia, Philippines, Mongolia, Thailand, India);
- WHO headquarters sent in Vietnam for two months some doctors from Mongolia in order to be trained on CBR approach, and some doctors from Cambodia in study-visit.

Five conditions to start and maintain new CBR projects in Vietnam

People's Committee, and community involvement

- health section;
- social affairs;
- education;
- mass organizations (Women's Union, Youth Union, Red Cross etc.);
- finance.

Manpower (who implement techniques of rehabilitation in CBR services)

- disabled persons, and family members;
- CBR workers (trained integrating in PHC, brigade nurse, Red Cross members, etc.);
- PT, rehabilitation specialists.

Referral system

- communal health station;
- rehabilitation unit in district hospital;
- rehabilitation department of provincial hospital;
- rehabilitation centers (NIP, Bach Mai in Hanoi and Children hospital in HCMC).

Materials

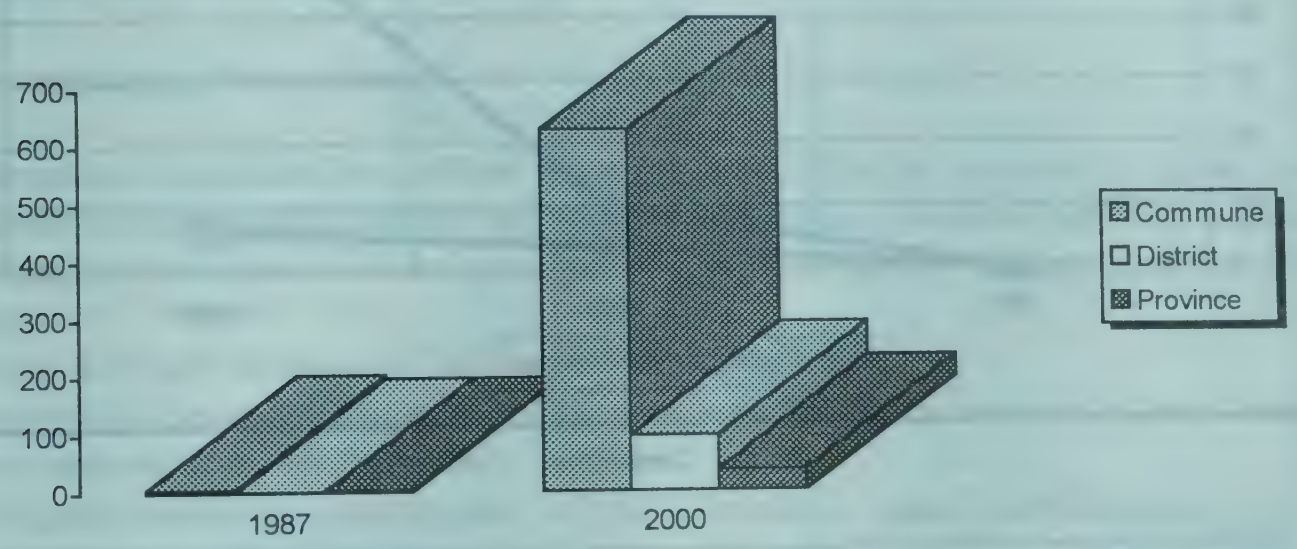
- material for making appropriate technical aids;
- manuals for training.

Funds

- from international organization (UN, NGOs);
- from local resources.

Fig.9: The results after 10 years of the National CBR program

Year	Level		
	Commune	District	Province
1987	6	1	1
2000	930	95	36



Some indexes[5]

- provinces covered by MoH's CBR program 25, districts 56, and communes 630;
- population surveyed 4,410,000 persons;
- the disability ratio 5.4 %;
- percentage of PWDs who needs rehabilitation 30%;
- children with disability 30-40%;
- the ratio between male and female, who have disability 44 and 56 %.

Among 118,919 disabled persons in need of rehabilitation:

- achieving good results in rehabilitation 96,324 (81%)
- achieving fair results 22,595 (19%)

Among 96,324 disabled persons achieving good results:

- adult 62,610 (38%)
- children 33,714 (35%)

of which:

- adult integrated in society with jobs 21,230 (38%)
- children having access to school 10,788 (32%)

The fact is that with Community-Based Rehabilitation approach about 70% of the disabled persons can be rehabilitated right at the community. Moreover, in its efforts the CBR program has educated people on disability prevention as well.

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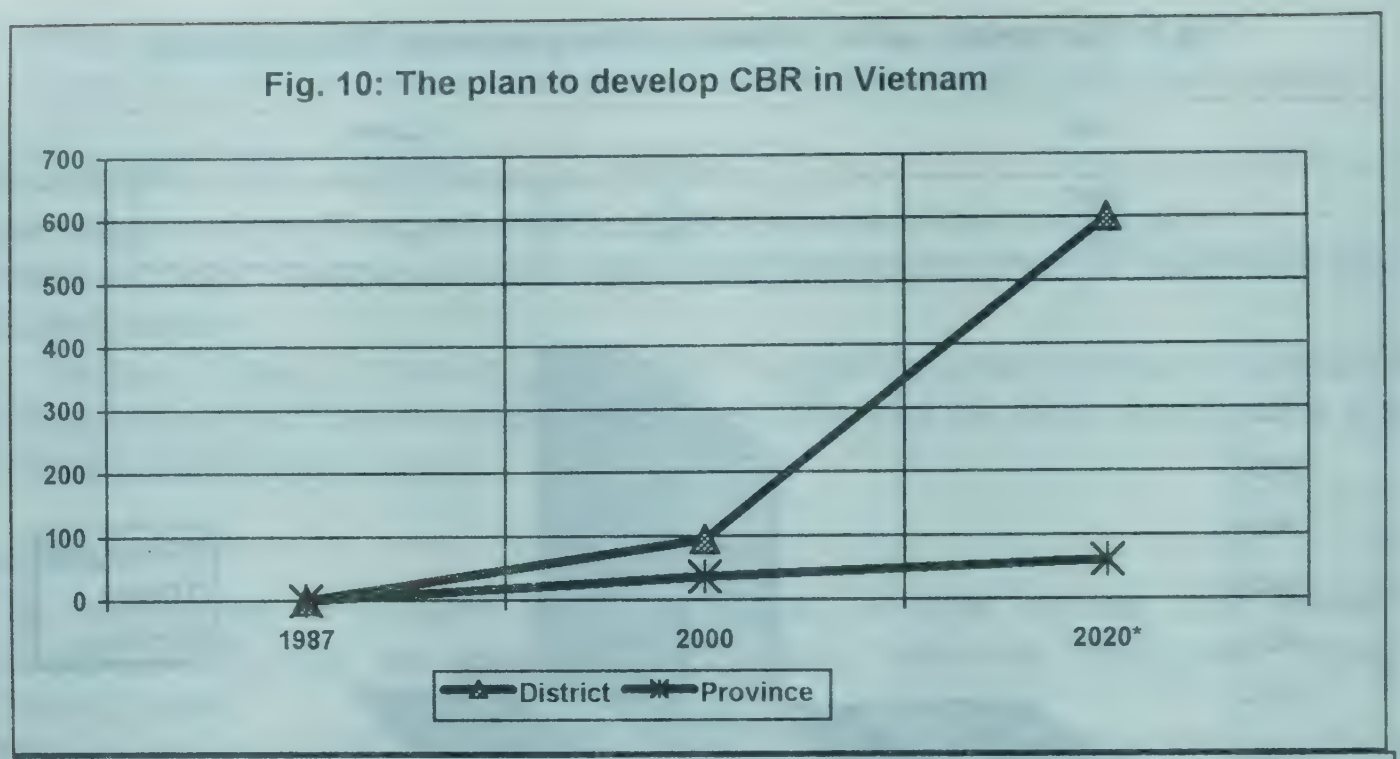
[5] MoH source (Hanoi, 10-1998)



Level	Year 1987-1997		Year 1997-2000		Year 2000-2020	
	Number	%	Number	%	Number	%
Commune	630	6.12	930	9.03	10.330	100
District	56	9.39	95	15.90	601	100
Province	25	40.98	36	59.00	61	100

* MoH estimation

List of provinces with CBR activities

North mountainous: Cao Bang, Thai Nguyen, Lang Son.
Middle region: Vinh Phuc, Phu Tho, Bac Giang.
Red river delta: Hanoi, Ha Tay, Ha Nam, Hai Duong, Haiphong, Nam Dinh, Ninh Binh, Thai Binh, Ha Tay, Bac Ninh, Hai Duong.
North central: Thanh Hoa, Nghe An.
Median central: Quang Binh, Quang Tri, Da Nang, Thua Thien Hue, Quang Nam, Quang Ngai, Phu Yen.
Central highlands: Dac Lac, Lam Dong.
Southern region: Khanh Hoa.
South-eastern coastal: Tay Ninh, Binh Duong, Vung Tau, Ho Chi Minh City.
Mekong river delta: Ben Tre, Tien Giang, Vinh Long.

Experiences

1. The health care network, and the community profile of Vietnam are very appropriate to develop CBR program.
2. The combination of all professions at all levels seems to guarantee the success of CBR.
3. The families of PWDs are of pivotal importance.
4. The financial help from international organizations is very important.

The major remaining shortcomings[6]

- high demand of rehabilitation but low responses (rehabilitation network is not yet largely expanded). Current establishments are located in narrow premises with old-fashionable equipment, lack of specialists in occupational therapy, speech therapy, and psychology therapy;
- demanding for high investment, but limited budget response;
- the combination between CBR and PHC is necessary but health network at local level has not met the demand of rehabilitation;
- rehabilitation needs the contribution of the community, but the socialization is still inadequate;
- applying social equality for the disabled persons, but the policy system for them is not uniformed;
- information, education, communication activities about rehabilitation need more considerations in order to involve the communities.

Proposals[7]

Pursuant to the Ordinance 37/CP on June 20th 1996 of Vietnamese government on orientation for Public Health Care towards the year 2020, the proposal for the development of rehabilitation are as follows:

- the government should allocate more funds in the CBR program;
- CBR should rely on the national health care program;
- the provinces, the provincial health services should obtain financial support not only from the MoH but also from local sources;
- to enlarge opportunities in jobs for the disabled persons in general, and inclusive education or special education for children with disabilities in the specific, besides changing the environment in order to provide at all disabled persons "barrier-free" access to public places;
- supports from international organizations are very needed and helpful to develop the CBR program in Vietnam.

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[6] MoH source (Hanoi, 10/1998)
[7] VINAREHA source

AIFO-VINAREHA project location

X. Overview of AIFO-VINAREHA CBR program

General information about AIFO

The Italian Association Friends of Raoul Follereau (AIFO, acronym from the Italian "Associazione Italiana Amici di Raoul Follereau") is an independent, voluntary and non-profit organization committed to promote equal rights and opportunities for the disabled persons. AIFO is recognized by European Union and by the Italian Ministry Foreign Affair for projects of development cooperation and collaborates actively with United Nation agencies, especially with the World Health Organization. AIFO started collaborating with the Rehabilitation Unit of the WHO for promoting CBR approach in the last ten years, and this has become one of the major areas of activities.

The main goals of AIFO's CBR programs

One
To support the existing National Rehabilitation programs in the countries where AIFO operates. To emphasizes a CBR approach in line with UN Standard Rules and the WHO's strategy of using local resources, structures, and run the rehabilitation activities (70-80%) at the community level.

Two
To support institution building of partner organizations. The focus is on organizational development and on increasing the advocacy capacity of local partners and DPOs.

Background

Who took the initiative?
In 1991, AIFO-WHO participated in a joint visit to Vietnam in order to assess the situation of PWDs in the country. The MoH of Vietnam asked for the collaboration of AIFO in starting CBR programming in some areas of the country. In the beginning, the Vietnamese Government proposed one province in the South, one in the Central and one in the Northern part of the country for starting that program. Due to logistical reasons, later AIFO suggested to concentrate the activities in three provinces in the North of Vietnam, and this proposal was accepted by the Government. A fourth province was added later after consultations with the National Leprosy Elimination Campaign program (LEC) to carry out a pilot study on the integration of rehabilitation care of disabled leprosy persons with other disabled persons in a community setting. The MoH of Vietnam indicated VINAREHA[8] as local partner for carrying out the program. AIFO carried out the first feasibility study for this project at the beginning of 1992 jointly with the rehabilitation unit of WHO. As a result of this a tentative plan of action for the introduction of CBR was prepared by VINAREHA. This plan was discussed during

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[8] **Vi**etnam **Reh**abilitation **A**ssociation (VINAREHA) is a local organization and all the persons having any kind of responsibility in rehabilitation field are members of VINAREHA. As organization has more flexibility for operating, in addition this also ensures collaboration with all the state infrastructures for the program. The board of VINAREHA is constituted by five persons belonging to different government bodies related to rehabilitation matters.

the second visit to Vietnam at the end of 1992, and a pilot project for testing the project methodology in Dong Hung district (Thai Binh province) was started in June 1993. The impact of this pilot project was assessed in a joint mission by AIFO-WHO in March 1994, and in 1995 a plan of operation was officially signed by the Foreign Relations Department of the MoH.

Brief information about the project
The project presented by AIFO, and co-financed by EU code: ONG/PVD/1996/141/IT is started on 1st June 1996 and expired on August 1999 (currently, AIFO still supports VINAREHA). The main objective of the project was to introduce and gradually expand a CBR program in four provinces of Vietnam. At the central level (Hanoi), a National team of CBR was be prepared which was then supposed to conduct training courses in pilot districts in four provinces. At the end of 1996, a change in the project plan was forced due to the sub-division of Nam Ha province into two provinces (Ha Nam, Nam Dinh). This meant that the project was now going to cover five provinces instead of the original four, even if the total project area was the same.

Project implementation

Local partner, date of creation and legal status
VINAREHA, was created on 15 March 1991, and legally recognized by Vietnam Government for coordinating and managing the CBR program.

Terms of agreement with AIFO
The Government of Vietnam has officially appointed VINAREHA as AIFO's partner for implementing CBR program. The overall responsibility for VINAREHA lies with its President Prof. Nguyen Xuan Nghien, who is also the chief of Rehabilitation Department at the Bach Mai hospital in Hanoi, and professor of Rehabilitation at Hanoi Medical College. Responsibilities for specific activities of CBR program have been distributed among the members of VINAREHA.

Experience of VINAREHA
It has been the first project of CBR to be managed by VINAREHA. However, the members of VINAREHA are figures of national importance in the field of rehabilitation. Some of them like Prof. Nguyen Xuan Nghien and Dr. Tran Trong Hai have been associated with the formulation of national policy on rehabilitation and have done pioneering work in the field of rehabilitation. Dr. Hai, and the National Institute Pediatric (NIP) in the Children's Hospital "Olaf Palmer" of Hanoi, have been collaborating with international NGOs for the past six years for starting CBR activities, specially for CWDs.

General strategy for Community-Based Rehabilitation

CBR can be considered as the Primary Health Care for rehabilitation and it is an important part of the strategy for reaching the goal of providing health for all. CBR is multi-sectoral approach in order to satisfy all the different needs of the disabled persons as: medical rehabilitation activities (physiotherapy and orthopedic aids), integration of the CWDs into regular schools, and vocational training for gaining employment as everybody. CBR program

has based above all on the transfer of knowledge about the disabilities and rehabilitation activities to the PWDs and their families.

Program locations

The CBR program has been implemented in five provinces[9]: Hoa Binh, Thai Binh, Ha Nam, Nam Dinh, and Ninh Binh.

Objective

General objective of the program is to rehabilitate the disabled persons and contribute to the development of the communities.

Plan of action

a. Starting a CBR project in a province
b. Assessment of political commitment of provincial authorities by the central team
c. Formation of provincial CBR Committee
d. Selection of pilot district and communes
e. Organization of provincial introductory seminar
f. CBR training course for district and commune level persons
g. Training of rehab. workers and first survey in the villages for starting the project
h. Setting up of rehabilitation services at district level
i. Identification of key persons
j. Prevention of disabilities at commune health stations
k. Field activities by district and commune level personnel
l. Refresher courses and upgrading courses
m. Rotating credit funds
n. Orthopedic aids for physically disabled persons
o. Supervision of activities
p. Data collection and analysis
q. Education for CWDs

Activities

Implementing team
The central team members from Hanoi have an important role in the beginning of any CBR project in a new province. They have to contact the provincial leaders and to motivate them for supporting the program. They are also going to take part in the initial training program in the provinces, until a team of key persons from the province is identified and trained in order to become trainers. The tasks and functions of the central team are:

- to develop a strategy and program plans for CBR project implementation;
- to formulate the role of each involved department in all administrative levels in the development and guidance of the CBR project;

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[9] Appendix: D

- to co-ordinate the involved sectors;
- to develop plans for the financial and human resources of the involved departments;
- to monitor, supervise, control and evaluate the implementing teams.

Initial preparation in the province for starting a CBR project
Once the central team is satisfied with the political willingness and motivation of the provincial authorities, a provincial CBR Steering Committee is formed. The vice-mayor of the province is asked to be the president, other members are provincial heads of health, labor and social affairs and education, and representatives of provincial mass organizations (e.g., Red Cross, Youth Union, VWU and DPOs) are also represented. The participation of these different groups is important for ensuring their involvement and collaboration with the project at all levels for carrying out the activities. The task and functions of this SC are:

- to study the disability problems existing in their province;
- to develop program plans;
- to conduct training for CBR workers;
- to monitor and control over the activities;
- to make reports to the central team.

Selection of districts and communes
In the beginning the project is launched in 8-10 pilot communes of one district of the province. These are later going to inspire and to serve as a model for other districts and communes. The selection of the right pilot (should be an average one "not too rich not too poor") area (should also reflect the different possibilities of local condition "urban and rural, easily accessible and difficult to reach areas etc.") is very important for the future success of the project, even though, the most important factor is the motivation of the political leaders and authorities to the project philosophy. Thus, a successful project is going to stimulate other districts and communes about the utility of CBR program and to ensure its extension. After the identification of the pilot district and communes, a CBR Steering Committee is formed which is similar to that formed at the provincial level, namely, the chief political authority of the district is nominated president of the SC, while the medical officer in charge of the district becomes the committee coordinator. The task and functions of this SC are:

- to assist the community in project planning and implementation;
- to train volunteers (field workers);
- to motivate, guide and address volunteers;
- to provide technical guidance for medical, social, education and work needs;
- to prepare reports.

Provincial introductory seminar
The introductory seminar is organized in the provincial capital and is of two day's duration. All important authorities, political, social leaders from the province, pilot districts and communes are invited to participate. The objective of this seminar is to raise public awareness about CBR approach and to prepare the different authorities for the needed collaboration. Moreover, the seminar explains the CBR methodology-philosophy as well as the roles which different public and private bodies can play in the project.

CBR training course for district and commune

Immediately following the provincial introductory seminar, the central team goes to the headquarters of the pilot district, for the district CBR course which is of 21 day's duration. Apart from the members of the central team, other specialists may be invited from Hanoi or from the provincial hospital as teachers to tackle individual topics. Head of the rehabilitation department at the provincial hospital as well as teachers from nursing and physiotherapy (PT) colleges participate in this course. The medical officer in charge for the district health services and two or three persons (health workers, teachers, Red Cross members, etc.) from each pilot commune also participate in the course. Other participants come from the district organizations (e.g., Women's and Youth Union). The aims of this course is to teach the participants about the diagnosis and rehabilitative care for seven major group of disabilities. During the course, participants practice carrying out "house-to-house" survey for identification of PWDs, as well as do assessments for identifying who can benefit from the CBR program. During the course they are taught in making simple orthopedic aids, and rather then giving them ready-made answers, they are encouraged to use their own imagination to find out innovative ways of responding to the problems related to disability and rehabilitation. The WHO manual "TCDP" on CBR is the chief teaching instrument and a copy of the manual in Vietnamese has to be provided to each participant. Moreover, the course gives opportunity to the central team members to assess the teaching abilities of participants, for identifying persons with leadership qualities, motivations, interest and capabilities about CBR, who can later become the "key persons and trainers" for the whole province.

Training of rehabilitation workers

The persons trained at district course, play an important role in the training of persons who are going to work in the field simply called "CBR workers". At least one or two persons from each village-hamlet are asked to undergo this training and so in each commune a total of 8-12 CBR workers may be trained. They can be the village health agents (brigade nurse), volunteers of different organizations members or family members and so forth. Each training course covers two or three communes and the total number of the participants may vary from 20 to 25. Like the district course, in the commune course also, the seven groups of disabilities and the rehabilitation activities are covered but here the emphasis is more on practical training and field work. The main teaching instrument remains the WHO manual "TCDP" on CBR. During the course the participants prepare a detailed map of their own commune in which each student can fill in information about their own village-hamlet. All the houses in the villages are surveyed using the WHO questionnaire and all houses having a disabled person are marked on the commune map. Thus, all persons identified are assessed for their need of training and supported through the CBR program. At the end of the commune training course, each CBR worker should know: how many PWDs there are in their village; where they live; how many of them need training and care; how many of them need orthopedic aids and so forth. The tasks and functions of CBR workers are:

- to identify PWDs through house-to-house visits;
- to train the PWDs and their families;
- to help produce simple aids;
- to report PWDs who need to be referred to the different sectors;

Setting up of rehabilitation department in the provincial hospital
For supporting the community-level activities and providing referral services for complicated cases, a rehabilitation department is set up or strengthened at the province hospital. Apart from the training of the personnel, a set of standard equipment is to be provided.

Rehabilitation services at the district hospital
At district hospital also, intermediate level referral services are set up through the establishment of rehabilitation units, with a standard set of rehabilitation equipment. Setting up of a two way communication system between the referral services and the communes is also very important so that persons treated at district and provincial hospitals can continue to be followed by commune level personnel.

Identification of "key persons"
The chief of rehabilitation department at the provincial hospital and the medical officer in charge of district health services are two "key figures" for the success of the project. In addition to them, some other key persons have to be identified in each province who show better motivation, willingness, interest and capabilities. These persons receive upgrading and refresher training courses for becoming resource persons and teachers for the extension of the program in the uncovered areas.

Field activities for district and commune staff
The district and commune level staff have the responsibility to visit the field for supervision of activities of the CBR workers and for data collection. To facilitate these field visits, each commune receives a bicycle while the district receives a motorcycle, and the district authorities are responsible for providing funds for petrol and maintenance. The tasks and functions of local supervisor are:

- to assist the community in the program planning and implementation;
- to train volunteers (CBR workers);
- to motivate, guide and direct volunteers;
- to provide technical guidance for medical, social, educational and work needs;
- to make reports.

Data collection
The data regarding every disabled person involved in the program is collected according the suggested-modules of WHO. Communes have to transmit their data to the districts once a month, districts send their data to the province hospital once in three months and these in turn also send the data to Hanoi every three months.

Recording and reporting
Four different types of questionnaires have been made and used (two for disability information at province and district levels)-(two for disability detection at commune and village levels), in order to identify type and seriousness of the disability and to confirm age and sex of the PWDs as well. Moreover, general information about the CBR workers are gathered. The following agreed indicators and the agreed method of data collection[10]:

[10] Appendix: F

- 1 A: general information at province level;
- 2 A/B/C/D: general information at district level;
- 3 A/B/C/D/E: general information at commune level;
- 4 A/B: general information about the CBR workers.

Data review

From the complete forms, the following data can be noted:

Table 1: Summary of area and population distribution

Province	Area (Km2)	Population	Density (x km2)	Urban districts (Towns)	Rural districts	Male	Female	Urban	Rural
Thai Binh	1,590	1,785,600	1,159.5	1	7	853,100	932,500	103,200	1,682,400
Nam Ha*									
■ Nam Dinh	1,670	1,888,400	1,126.7	2	8	918,800	969,600	254,200	1,654,200
■ Ha Nam	830	734,400	874.3	1	5	340,000	394,400	87,850	646,650
Hoa Binh	4,749	757,600	159.5	1	9	376,000	381,600	104,900	652,700
Ninh Binh	1,420	884,100	622.6	2	6	432,800	451,300	113,400	770,700

* At the end of 1996, Nam Ha province has been divided into two provinces: Ha Nam and Nam Dinh.

Table 2: Medical staff (as of 30-9-1999 by province)

Province	Population	Doctors	Assistant doctors	Nurses	Midwives
Ha Nam	734,400	275	525	450	145
Nam Dinh	1,900,000	890	858	930	286
Thai Binh	1,785,600	926	783	552	287
Ninh Binh	884,100	367	696	366	129
Hoa Binh	760,000	304	1,020	650	161

Table 3: Hospital beds by province (as of 30-9-1999)

Province	Hospitals & Clinics	Sanatorium	Medical service units
Ha Nam	1,280	-	771
Nam Dinh	2,215	70	1,190
Thai Binh	2,174	80	2,450
Ninh Binh	1,080	100	715
Hoa Binh	970	-	840

Table 4: Background information of village level rehabilitation workers (between 1996-1999)

Province	Total Population	Number of village level rehab. Workers		Background of village level rehabilitation workers						Drop out
		Male	Female	Brigade nurses	Red Cross volunteers	Teachers	War Veterans	Family members	Others	
Hoa Binh	760,000	70	130	10	18	8	0	160	4	33 (16.5%)
Ha Nam	734,400	361	485	263	80	24	8	286	185	296 (34.9%)
Thai Binh	1,785,600	303	402	85	189	106	145	132	51	180 (25.5%)
Nam Dinh	1,888,400	177	413	222	141	34	43	72	78	52 (8.8%)
Ninh Binh	884,100	65	85	18	80	10	8	23	11	0
Sub-total		**976**	**1,515**	**598**	**508**	**182**	**204**	**673**	**329**	**561**
Total		**2,491**		**1,106**		**386**		**1,002**		(11.3%)

Table 5: Summary of the number PWDs identified

(between 1996-99)

Province	District "communes with CBR/ total communes"	District Population	Number of PWDs "Disability rates" ****	PWDs in need of rehabilitation " % of total PWDs"	PWDs who have shown progress in the last 3 years "% of PWDs in need of rehabilitation"	PWDs who have been integrated in the society in the last 3 years "% of PWDs in need of rehabilitation"
Thai Binh	Dong Hung (26/36)	144,654	4,988 (3.44%)	2,010 (40.30%)	966 (48.10%)	464 (23.10%)
	Tien Hai (15/35)	58,701	2,885 (4.91%)	1,589 (55.10%)	68 (4.30%)	50 (3.14%)
Nam Dinh	Y Yen (22/32)	147,026	5,145 (3.49%)	3,351 (65.10%)	1,975 (58.90%)	663 (19.70%)
	My Loc (10/10)	66,366	3,846 (5.79%)	806 (20.90%)	372 (46.15%)	297 (7.72%)
Ha Nam	Binh Luc (21/21)	152,120	9,769 (6.42%)	4,347 (44.50%)	2,497 (57.40%)	709 (16.31%)
	Kim Bang (21/21)	137,672	7,727 (5.60%)	1,237 (16.00%)	381 (30.80%)	301 (24.33%)
Hoa Binh	Lac Son (14/29)	43,078	1,494 (3.46%)	313 (21.00%)	48 (15.30%)	22 (7.02%)
	Kim Boi (10/37)	42,542	2,736 (6.43%)	560 (20.50%)	176 (31.40%)	4 (0.71%)
Ninh Binh	Hoa Lu (16/16)	96,391	7,496 (7.77%)	3,527 (47.60%)	183 (5.18%)	10 (0.28%)
	Tam Diep (7/7)	35,014	2,421 (6.91)	1,230 (50.80%)	23 (1.90%)	16 (1.30%)
Total		**896,564**	**48,494** (rate from 4 districts = (8.60%)	**21,151** (43.61%)	**6,689** (31.62%)	**5,228** (24.71%)

* Identification based on house-to-house survey (based on WHO classification of seven functional categories of disabilities).

* * Progress criteria based on ability to perform activities of daily living (ADL, self care, or move around the house/village).

* * * Integration criteria based on increased independent ability (to attend school, participate in family life, do a job, carry out household activities, or take part in community activities).

* * * * Rates have been calculated for four districts that have completed surveys of all communes.

Fig. 1: Districts survey based on house-to-house

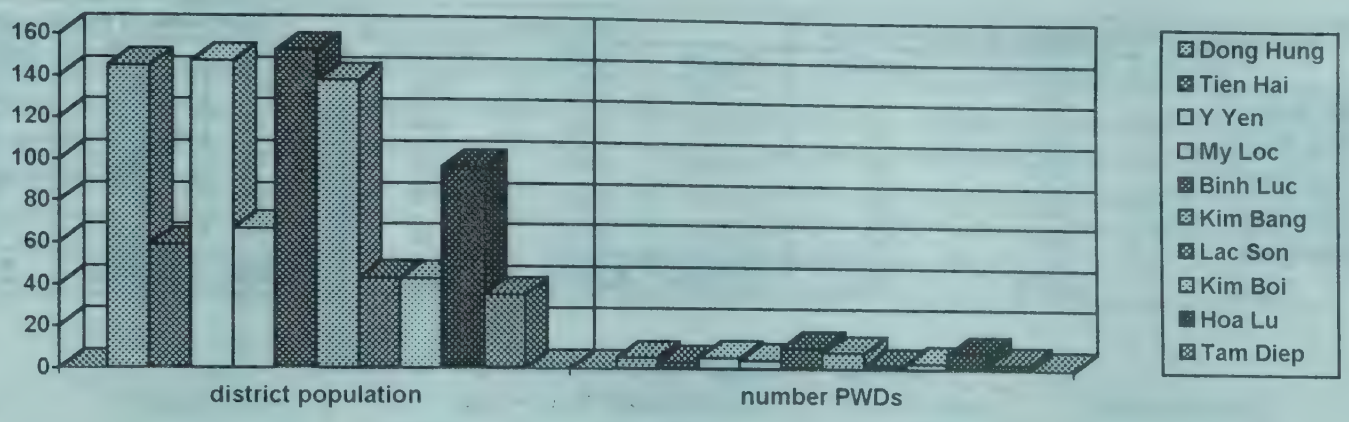

Fig. 3: PWD who have shown progress
(in the last 3 years)

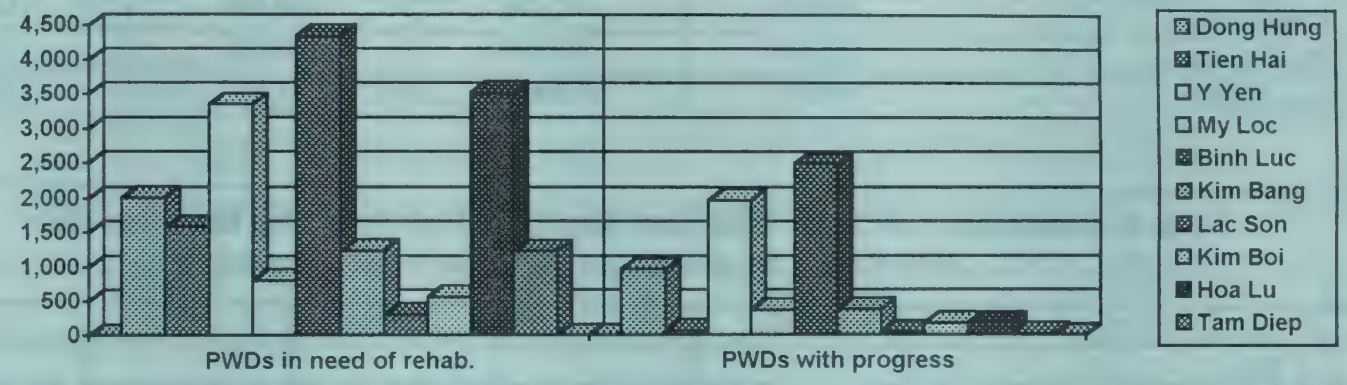

Fig. 3: PWD who have shown progress
(in the last 3 years)

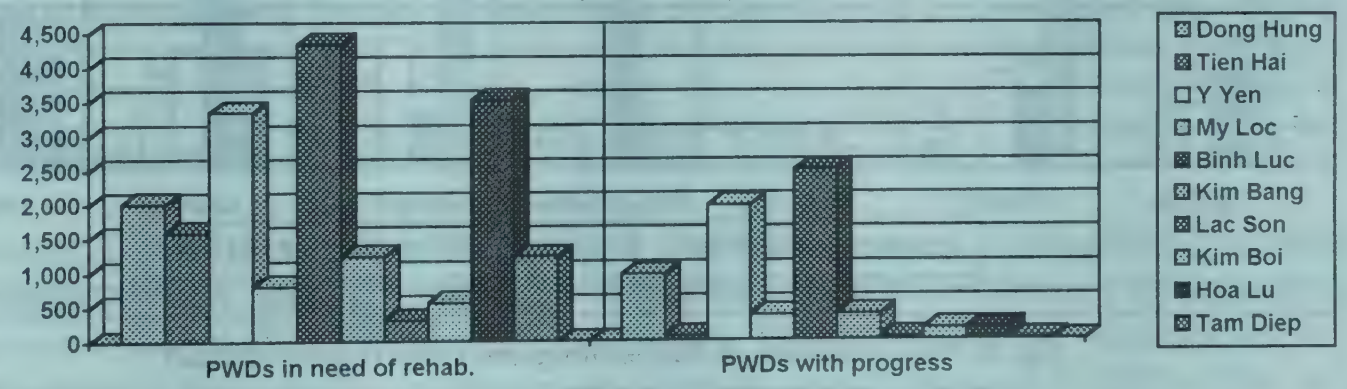

Fig. 4: PWD who have been integrated
(in the society)

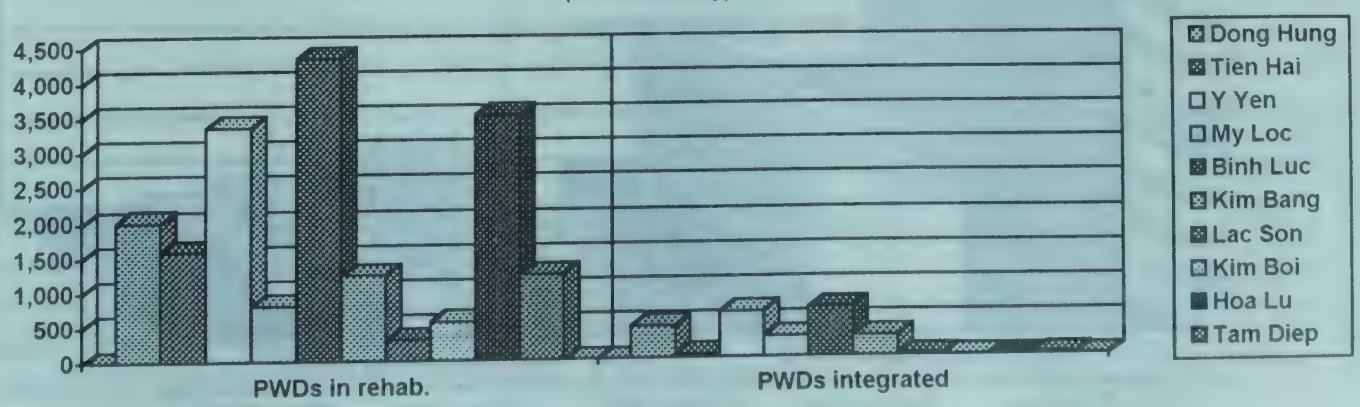

Table. 6: Number of grade schools, classes, and classrooms
(in school year 1998-1999)

Province	Number of grade schools		Grade classes			Classrooms of grade schools		
	Elementary	Secondary	Primary	Middle	Secondary	Primary	Middle	Secondary
Ha Nam	255	18	2,718	1,529	350	1,805	1,365	257
Nam Dinh	536	39	6,141	3,721	854	4,119	3,344	729
Thai Binh	572	35	5,366	3,650	928	3,573	2,478	705
Ninh Binh	293	20	3,658	2,107	473	2,068	1,531	365
Hoa Binh	378	30	4,641	2,048	432	2,771	1,348	327
Total	**2,034**	**142**	**22,524**	**13,055**	**3,037**	**14,336**	**10,066**	**2,383**

Table. 7: Pupils of grade schools in school
(as of 30-9-1999 by province)

Province	Total of pupils	Primary school	Middle school	Secondary school
Ha Nam	182,543	93,138	69,824	19,551
Nam Dinh	435,365	217,126	170,622	47,617
Thai Binh	375,330	181,456	142,846	51,028
Ninh Binh	232,430	116,657	88,839	26.934
Hoa Binh	198,411	108,859	70,001	19,551

Fig. 5: Identification of CWDs in Ha Nam, Nam Dinh, Ninh Binh, Thai Binh, Hoa Binh
(different disability groups, based on "House-to-House" survey)

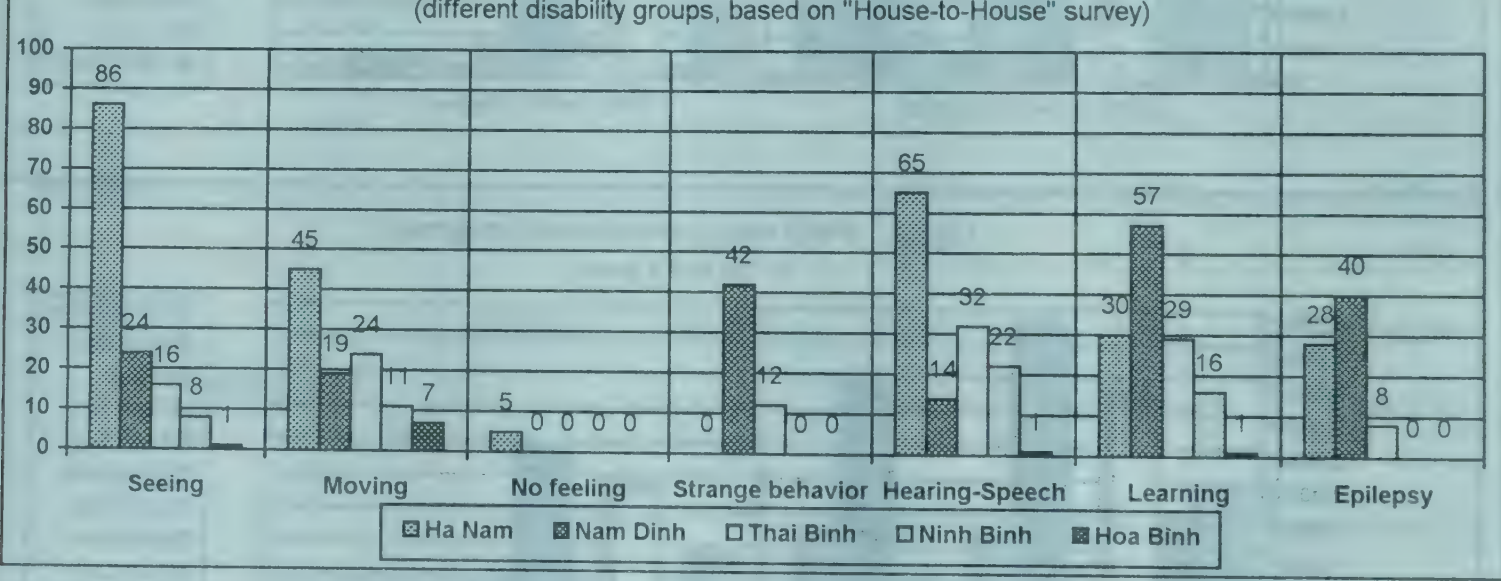

Fig. 6: Total number of CWDs integrated into regular school

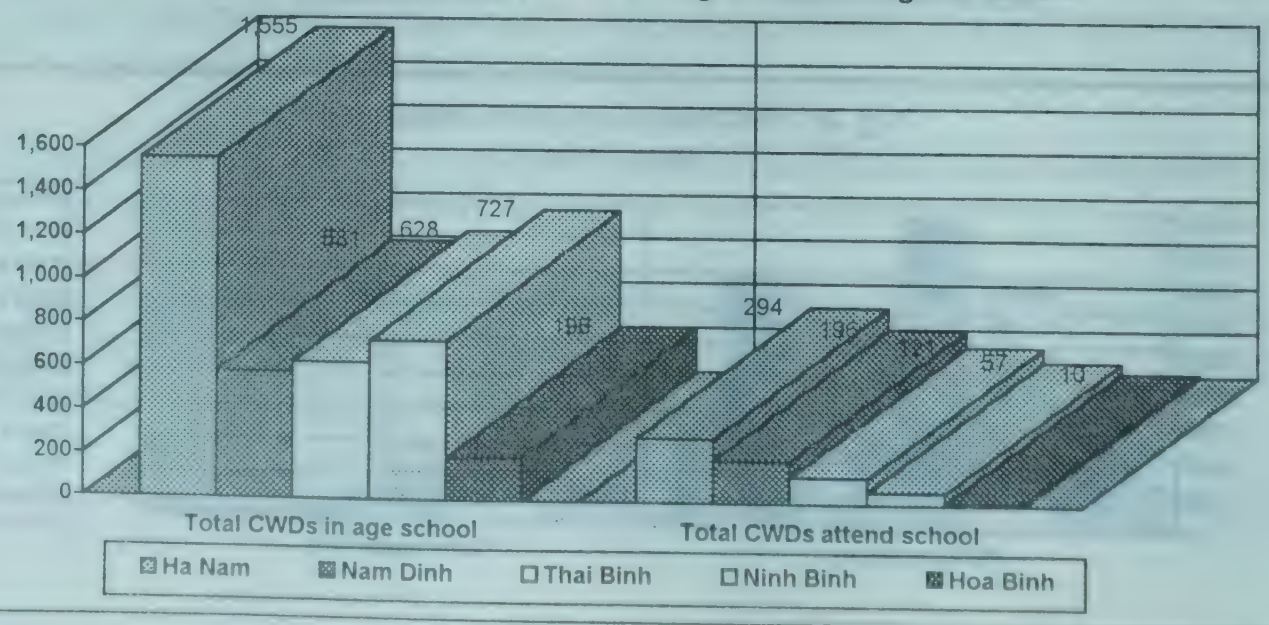

Table 8: Teaching materials printed
(between 1995-1999)

Description	Number copies
WHO manual "TCPD"	9,300
CBR Outline	3,500
Monitoring patients cards	3,000
VINAREHA newsletter	3,000

Table 9: Equipment provided
(between April 1994 to November 2000)

Province	Description				
	Transportation	**Teaching materials**	**Medical rehab. equipment** (X province + district level)	**Medical rehab. equipment** (x commune level)	**Office materials**
Hanoi	- 1 Mekong jeep - 1 Toyota minibus - 1 Motorbike - 1 Bicycle	- 1 Camera - 1 TV set - 1 TV camera - 1 Overhead	- Speech therapy equip. set	-	- 2 P.C. + 2 print. - 2 Air-con - 2 Photocopier - 1 Safe + 1 Set office furn.
Hoa Binh	- 3 Motorbikes - 36 Bicycles	- 1 Overhead	- 2 Sets	- Set x 16 Comm.	- 12 Drug wardrobe - 1 PC+1 printer
Thai Binh	- 3 Motorbike - 10 Bicycles	- 1 Overhead	- 2 Sets	- Set x 10 Comm.	- 6 Shelves medicine - 1 PC+1 printer
Ha Nam	- 4 Motorbikes - 27 Bicycles	- 4 Overheads	- 3 Sets	- Set x 21 Communes	- 9 Shelves medicine - 1 PC+1 printer
Nam Dinh	- 4 Motorbikes - 22 Bicycles	-	- 2 Sets	- Set x 8 Communes	- 9 Delivery bed - 1 PC+1 printer
Ninh Binh	- 5 Motorbikes	-	- 1 Set	- Set x 8 Communes	- 9 Delivery bed - 1 PC+1 printer

Description of a standard set of medical rehabilitation equipment:

Wooden therapy, Electric stimulation machine, Exercise bicycle, Galvanic machine, Ultraviolet + Infrared lamps, Battery recharge power unit, Weight tools, Rubber ball, Running bench.

List of training materials used in the CBR training courses:

WHO manual "TCPD"; Guideline for CBR; VINAREHA annual newsletters; Disabled Village Children; Where there is no doctor; Workshop on CBR and country experiences of CBR programs; Prevention of disability; Rehabilitation for stroke patients; Essential action to minimize disability; Therapeutics exercises-Foundations and Techniques; CBR of the rural blind - A training guide for field workers; Occupational therapy; Inclusive Education; Speech therapy.

Table 10: Summary of training courses
(conducted between 1994-99, includes training conducted during pilot phase)

Type of training	Number Organised	Total number of participants
CBR awareness seminar (for province and district leaders and others interested)	15	1,563
CBR supervisor training at district and province levels	11	741
CBR worker training at commune level	20	2,235
Special courses: **Bobath techniques** (restoration of motor function after stroke, how to use appropriate technology), **credit fund seminar, CBR management.**	7	184

Table 11: Number of technical aids obtained, produced or distributed
(between 1994-99)

Province	Wheelchair	Walking aids	Crutches	Hearing aids	Eye glasses	Other
Hoa Binh	32	-	40	-	-	-
Ha Nam	35	26	150	45	386	-
Thai Binh	21	82	38	19	27	- 33 Parallel bars - 21 chairs x (CP)
Nam Dinh	39	276	644	638	18	- 18 Prosthetics - 580 Parallel bars
Ninh Binh	25	38	27	17	40	-

Table 12: PWDs who have benefited from vocational training or income generation
(between 1996-1999)

Province	Vocational training	Found employment	Given loan to begin small business
Hoa Binh	-	7	3
Ha Nam	28	100	7
Thai Binh	10	16	31
Nam Dinh	110	216	15
Ninh Binh	5	9	9

Results

After five years of implementation, the impact[11] of the AIFO-VINAREHA CBR project in five provinces of Vietnam has resulted very positive. CBR project has shown a real effectiveness in its efforts for improving the quality of life of the PWDs. A some up of results can be illustrated as follows:

a. from a total of 48,507 PWDs, 18,970 were in need of rehab. (39.10%), 6,689 of them have shown progress (35.20%), and 2,536 have been integrated in the society (13.36%);
b. from 3,687 school age CWDs, 678 has attended regular schools (18.38%);
c. 79 PWDs have run their small business according to the SCs regulation;
d. community awareness on disability related matter have considerably improved;
e. good impact on development, and training manpower for the rehab. referral system;
f. the medical referral system has supported the CBR program implementation.

[11] Evaluation by Dr. Manoj Sharma

XI. The relevance, the effectiveness, and impact of the AIFO-VINAREHA CBR program

The relevance

So far, AIFO-VINAREHA CBR program, has provided material benefits to the PWDs, their families, and the communities covered, including supplying aids and equipment, funding for operations, and has facilitated access to programs such as inclusive education and poverty alleviation. Training has empowered PWDs themselves, their parents, and volunteers. Of course still some weakness and threats, but there are also many stories to illustrate the effectiveness of training to identify the needs of PWDs and setting objectives based on these. For instance, the impression given by some Steering Committee members, volunteers and parents is that there has been a shift in attitude in the community. In fact, there is more concern for PWDs, and there is also less "*teasing*", and parents have more optimistic view of their children's future. Moreover, the parents of disabled persons are supporting one another, and now have more knowledge of how to build on their children's abilities. With a more positive view of their disabled persons, they fell less vulnerable, and are drawing closer to neighbors, who also have a greater understanding that disabled are not "*disposable and useless*" an attitude that is often applied, even to children with relatively minor impairments. In some areas, it still remains as major obstacle to overcome the belief that parents of a disabled must have committed some sin in this life, or past lives, and that given birth to a disabled child is their punishment.

The effectiveness

There are many positive benefits for the PWDs, and the program's justification is that, it is helping disabled persons to realize their potential inclusion in their communities as well as the communities to have better understanding about disability related-matter. The program have delivered many materials and other benefit, aids and equipment have been supplied, rehabilitation techniques employed, and operations paid for. Knowledge has spread from professionals to volunteers and parents. Moreover, through the involvement of all community (which have included disabled and non-disabled persons), social activities have been initiated, even though still weak. The volunteers that still working are advocated for the program, and mothers reported an increasing confidence in themselves and their PWDs. However, the participation of PWDs remain low. Despite, the importance and relevance of such program, and even after several years of CBR implementation, the development of focal resource people is limited, and above all local resource still not accessed.

The impact

The impact of CBR program at local level has been positive. It has alerted people to new ways of working with PWDs, which helps very much to reveal their abilities. It has been empowering indeed, for parents and volunteers to realize that there is a very simple technology which they can use, that is systematic, which can produce positive, and practical results, and radically changes their expectations of their PWDs' life chances.

XII. Summary of observations, reflections, comments, and recommendation

Observations

Psycho-social problems are emphasized

Most of the households state that the most important problems in they experience are of psycho-social nature. In fact, almost one third (1/3) of PWDs expressed a desire to improve their relationship with their family and/or household members as well as the community at large. This is a strong indication that interpersonal relations are a priority and that attitudes towards disability must be improved both at the personal and at the community level. Moreover, more than half of households reported financial difficulties and poor access to proper medical care and educational institutions as a challenge.

Work is an option many choose

Despite not being paid adequately and often ending up with jobs that are less appealing and career oriented than others, PWDs are seeking employment and even manage to attain a certain degree of financial independence. Substantial differences in economic activity exist between people living with disabilities and those without. Although, this rate is low but it still promising, and it shows that PWDs can be productive members of society and they can contribute to its development. However, that work and income are often not adequate for PWDs, and the most likely source of income for PWDs are either part time or seasonal jobs.

Lower school attendance for CWDs

In the areas covered by AIFO-VINAREHA, the percentage of children without disabilities who ever attended school is around 91%, while the corresponding percentage of the CWDs seems to be around 18.38% (national level average around 0.36%). The educational attainment of those living with disabilities is remarkably low as compared to that no disabled people. Of those, who were lucky enough to attend school only 36.00% were able to do their homework by themselves the rest needed extra help. Now, despite a recognition that Inclusive Education offers better access and improvement in the quality of education for all disabled persons in school ages. Unfortunately, in today's Vietnam there are still obstacles to the implementation of a national policy of "*inclusion*" for children with disabilities. Being aware of these obstacles can help to have a look at the data on education collected by the National Institute Education and Science.

A desire for more formal and informal training

Most of the disabled persons interviewed expressed the need to receive formal schooling, vocational training or a chance to be enrolled in some rehabilitation center. For instance, their desire to receive vocational training is linked to centers that train only disabled persons, but these vocational centers targeting only disabled persons tend to further isolate them from society, rather than promote their integration. In addition, equipment and human resources in such centers are often limited and of poor quality. Moreover, the possibility of receiving vocational training in an simple or ordinary training center, rather than the specialized one, is still perceived as a realistic option. Thus, effective approaches for integrating disabled persons must be further explored directly in their communities.

The right to be fully integrated
Disabled persons have a right to be fully integrated in their own communities not only in terms of schooling and to access services that meet their needs. The principle of full integration is well stated in the Universal Declaration of Human Rights, the UN Standard Rules on the Equalization of Opportunities for PWDs and the Salamanca Statement. These international documents serve as guidelines for the work undertaken by AIFO.

Public health must be strengthened
In the area of health, the collected information tells the number of hospitals, health centers, clinics, doctors and nurses present in the country, whether the availability information about physiotherapy or any kind of specialized equipment still confused and not well known. Moreover, the medical staff's experience with disability still limited, as well as the level of experience or lack of it in diagnosing, treating and classifying seven major types of disabilities. That is why, the current public health care system often fails to identify disabilities and intervene at an early stage in a child's life.

Disabled People's Organizations are a resource
The Disabled People's Organizations could represent an important resource for designing, planning and providing services for disabled persons. Many of the members that belong to these organizations are skilled but lack financing to start up (e.g., income generating activities). They should represent a valuable source of know how for the communities they live (at least in this area). The DPOs experience and first-hand knowledge of disability places these organizations in a unique position for planning and coordinating social services together with the government sector. Through DPOs, the public sector has a chance to collaborate directly with organized members of civil society (e.g., NGOs) and with people who are knowledgeable, willing and interested about disability. Very interesting is that, many DPOs' member working in different government offices, nevertheless there is active resistance by the government to allowing these groups to develop.

Are the Non-Government Organizations underutilized?
Non-Government Organizations and the services they provide in the country are highly profiled value. According to NGO Directory (International NGOs, Foundations & Trusts in Vietnam) 1999-2000, 31 INGOs out of a total 271 INGOs operate in Vietnam, are working in the field of disability. Hence, INGOs represent an important resource for the country, which probably is not yet fully utilized for providing services to disabled persons, despite most INGOs are quite resourceful in terms of available funds, staff and equipment. Therefore, with a more deeper collaboration and co-operation among the INGOs themselves, Ministries and different bodies involved in disability related matters, can develop a coordinated rehabilitation sector in order to provide more opportunities and to maximize the services for disabled persons.

Reflections

How do the PWDs benefit from CBR?
The Community-Based Rehabilitation program has its strength in mobilizing local people, besides providing them means in order to improve the general conditions of disabled persons.

Even though, still remain many shortcomings, the work that has been done in Vietnam is really impressive.

Medical progress
The project has benefited disabled persons with certain disabilities more than others, partly depending on the skill and training of the CBR workers:

- Difficulties in moving, is the most frequent disability. There has been remarkable progress by training with walking bars, walking chairs and crutches that are locally made. There has also been remarkable progress in the equipment (provided by AIFO and other INGOs) available in the rehabilitation units at provincial and district levels;
- The CBR workers' skill in coping with difficulties as strange behavior, speech-hearing, blindness is not impressive. While the CBR workers give good advice about the protection of children and of disabled persons in general with epilepsy, and how drugs can cure or reduce their fits;
- Not every type and degree of disability can be expected to respond to rehabilitation training, whether or not of CBR type.

Educational and social aspects
The educational and social aspects of CBR have received less attention than the medical ones. The CBR workers do certainly try to influence the attitudes of the parents when it comes to promoting the independence of disabled persons and their contribution to household work and to learn simple tasks. They advise the parents specially for children to let them explore the neighborhood, and particularly to go to school.

Integration in the community
It is difficult to say anything substantial about the impact of Community-Based Rehabilitation program at a community level. People maintain that the attitudes towards the disabled persons have changed for the better. Yet, the Vietnamese often give the normative answers, explaining how things ought to be, not noticing how they are. By and large, the disabled persons and their families were rarely involved in CBR activities, except most of the time, as clients. In fact, there are none of them as members in Steering Committees or as resource persons within the program. It seems that the disabled people lack of representation. However, the family networks stand by their disabled and quite many families think that they have support from their neighbors and from CBR program.

Comments

Current policies and services in Vietnam

Education
- When talking about children or adults with disabilities, people often think of specialized institutes and exclusive centers. Most of people working in these places have very little professional knowledge and academic training on disability;
- In many provinces, the admission of children with disabilities in the regular schools it does happen as a rule but still depends very much on the point of view of each individual

teacher or head-teacher, who in turn depends very much on his/her own experience rather than academic knowledge, if having disabled children in class;
- For years, the integrated education program for disabled children in mainstream schools has already done by National Institute Education and Science. The only problem of this strategy/program is that it is still a pilot one with funding provided by NGOs, and has never been considered a national program.

DoLISA
This sector's main focus is disabled people in schools or centers under its direction and veterans disabled during the revolutionary war. Hence, the majority of disabled persons living in communities are therefore out of its reach.

Construction and transportation sectors
Public utilities and infrastructure system are designed regardless of the accessibility of disabled persons. No specialized sections for the disabled have been found on roads, in schools, theatres, churches, pagodas, and even public restrooms.

Health sector
Major concentration of this sector is medical treatment and physical rehabilitation (e.g., Community-Based Rehabilitation implemented by MoH), rather than to improve and expand intellectual development among adults and children disabled.

Committee for the Protection and Care of Children
The CPCC has the responsibility for the national plan of action for children throughout Vietnam, which includes "*care of disabled children*". The care usually involves gifts of rice, milk, money, and gifts on festival and national days.

Effectiveness and sufficiency brought up by current services
The vast majority of disabled people specially the children have very few chance to participate into both family and community life. In general, there are likely enough provisions and services given by the government, which could assure a better care of disabled people and in particular of disabled children. However, the tendency of sectorial bias, a direct result from separated responsibility and complicated bureaucracy have made these facilities insufficient and often unrealistic specially for disabled children.

Recommendations

Survey[12]
An appropriate body (e.g., a National CBR coordination?) should conduct a representative national baseline survey on disability prevalence, causes, and types, including information on background characteristics, services received, and needs of disabled persons. All provinces should be included and the sample should be large enough to have statistically valid estimates of the major types of disabilities at the provincial or regional level, as well as the national level. Such large-scale survey could be conducted collaboratively by MoLISA, the MoH, and the General Statistical Office (GSO) because of their previous experience in conducting large

[12] A Meta-Analysis of the data by Thomas T. Kane (October 20, 1999)

survey and/or disability data collection. The survey effort should be done in close consultation with the INGOs working in the disability field in Vietnam. International financial and technical support will be necessary for designing, implementing, and analyzing such a large-scale data collection.

Introduce CBR as national strategy
Recognizing CBR as cost-effective decentralized approach, the Government should support the efforts already made, and to extend CBR network all over the country. The Government's commitment to the development of CBR program should be expressed in the adoption of CBR strategy as one of the national development policies.

Ministries and INGOs
Ministries and INGOs should collaboratively identify, develop, and use key variables, definitions, and indicators to measure the progress of disability programs, in order to evaluate the impact of the implementation of the November 1998 Ordinance on Disabled Persons in Vietnam.

Special and/or Inclusive Education
Regardless of the exact number of children with disabilities benefiting from special education and inclusive education programs, still clearly that the number of CWDs benefiting from such programs fall far well short of the total number of CWDs in need of such educational programs. The relative role of IE programs versus SE programs to meet the education needs of CWDs will need to be considered in discussions and implementation of action plan based on the November 1998 Ordinance on Disabled Persons.

Encourage disabled persons to organize self-help movements
The establishment of a national cross-disability organization probably would be able to more strongly contribute to self-reliance of all categories of disabled persons.

Proper project document
In some cases, a more clear project document with a coherently formulated goal hierarchy, action plan, targets and budget, to facilitate projects implementation and future evaluations would be needed, if not necessary.

Follow-up
More follow-up data on disabled persons receiving rehabilitation services needs to be collected some time after the disabled persons receive their rehabilitation services (medical/surgical, physical therapists, IE, SE, vocational training, and so forth) in order to determine the longer-term impact of these efforts on improving the lives of PWDs.

Information status on Person with Disabilities
More information is needed in the areas of poverty status, marital and family living arrangements and support, community support for disabled persons, percent in need rehabilitation, percent receiving rehabilitation, and above all some indicators for measuring percent of PWDs integrated into the community (e.g., friends, participation in recreational, social and economic activities, aspirations and needs for the future, community attitudes, beliefs, awareness and behavior concerning PWDs), would be needed.

Appendices

Appendix A: Other rehabilitation activities by NGO's

List of some NGOs active in the field of rehabilitation in Vietnam

- *Comitee Two* (K2-The Netherlands). Field office in Hanoi since 1991. This organization is far the most and longest active organization in this field in Vietnam. They have worked in Vietnam since 1973. Special Education programs and Vocational training programs for blind, deaf, mentally and physically handicapped children have been their main focus since 1976. It consists of provision of teaching materials to the SE schools, SE teacher training, and development of medical support programs. The provinces Cao Bang, Quang Tri and Hau Giang are focus provinces in their programs.
- *Radda Barnen* (Save the Children/RBSweden): field office in Hanoi since 1991. This organization works for the rights of the child and is active in Vietnam since 1987. RBS was the first to start CBR project, as a pilot project in Tien Giang in 1987. Since then they started CBR project in HCMC, Hai Hung, Vinh Phu and Thua Tien Hue. They work mainly with national SC of MoH (Dr. Tran Trong Hai) and PCs. Recently they have expanded their activities also to the field of Community Integration of Special Education (CISE). RBS supports its project financially and by bringing in foreign experts in this field as consultants. They finance also equipment for-and upgrading of rehabilitation departments in children hospitals and various activities concerning the rights of the child.
- *Save the Children Fund* (SCF/UK): field office in Hanoi since 1991. SCF/UK became active in Vietnam in 1984 with some small PHC assistance in HCMC. SCF/UK expanded their assistance in 1987 and since then they support a variety of projects in Vietnam which include the Center for the Handicapped in HCMC which has been assisted with some equipment and with some training in community work and SE.
- *World Vision International* (WVI-USA): field office in Hanoi since 1991. WVI is active again in Vietnam since 1998. Most of their work is concentrated in Quang Nam Danang. This work includes some PHC projects, a literacy and rehabilitation project for the blind and SE for deaf children in Danang.
- *Handicap International* (HI-France): active in Vietnam since 1989. Their CBR project in Da Lat, Duc Trong and Bao Loc and development of provincial reference centers through training courses for the making orthopedic devices by using appropriate technology.
- *Catholic Relief Service* (CRS-USA): active in Vietnam since 1991. Their support a variety of projects in Vietnam. In CBR they are active in the field of Inclusive Education through the cooperation with NIES in Hanoi, Ninh Binh, Ha Tay, Quang Ninh and Hoa Binh provinces.
- *World Concern* (WCI-USA): active in Vietnam since 1992. The purpose of their program is to enable CWDs to address their own social, vocational and economic needs. Projects location: Hai Duong, Danang and Quang Nam provinces.
- *Medical Committee Netherlands Vietnam* (MCNV-The Netherlands): active in Vietnam since 1991. Their main objective is to support PWDs and their families in a sustainable participatory way. Their CBR project is in Cu Jut district, Da Lat province.
- *Pearl S. Buck International* (PSBI-USA): active in Vietnam since 1991. Their purpose is to help deaf and hearing-impaired children have access to IE and opportunity to become accepted and productive members of society. The projects location: Bac Ninh, Hung Yen and Thai Nguyen (North); Long An, Dong Nai and Dong Thap (South).

- *Health Volunteers Overseas* (HVO-USA): active since 1992. Interdisciplinary teams of USA health care professional volunteers have been recruited to come to Vietnam to conduct short term training courses and workshops on clinical topics.
- *Vietnam Assistance for Handicapped* (VNAH-USA): has focused on the rehabilitation of people with moving disabilities. VNAH has cooperated with MoLISA to establish an orthopedic plant at the Central Vocational Training Center No 2 in HCMC (at Thu Duc, run by MoLISA). Since 1992, VNAH has been supporting the Prosthetics and Rehabilitation Centre at Can Tho (run by MoLISA).
- *Vietnam Veterans of America Foundation* (VVAF-USA): active in Vietnam since 1995. VVAF supports an orthotic clinic and lab. at NIP, and a similar clinic on the department of rehabilitation at Bach Mai Hospital both located in Hanoi. Using NIP and Bach Mai Hospital as joint bases of operation, VVAF implement a mobile outreach program into provinces surrounding Hanoi. The mobile outreach program want to bring rehab. services closer to patient's home, villages, and communities.
- *POWER The International Limb* (UK): is active in Vietnam since 1998 for helping and create a prosthetic &orthotic service capable of providing for the needs of all mobility-disabled, and to generate an organization which is sustainable in the long term.

International cooperation achievement in rehabilitation field

Over last years (1996-1998) the rehabilitation branch has received assistance from international organizations and NGOs, making great contribution to the development of the rehabilitation on the following aspects:

1. CBR program: from the initial assistance of the international organization and the State's support to recent years, this program has brought basic benefits of caring PWDs. The goal it has been to improve the quality of life, to create equal opportunities for them, and to participate in the process of social integration. In comparison with other regional countries, CBR program in Vietnam has succeed in many aspects both in quality and quantity, although with modest investment.

2. Establishing training program for secondary, university and post graduation on the rehabilitation. At present, Hanoi Medical faculty has enabled to train intern doctor, associate Ph.D and Ph.D on rehabilitation. The National Secondary Medical School No. 3 has got many experiences on training technician of physiotherapy with Colleges and University.

3. Expanding facilities, upgrading and building new centers for rehabilitation at central to local levels, some national and provincial hospitals and rehabilitation faculty in universities and secondary schools.

In brief, over the last 12 years, thanks to the assistance particularly from INGOs and State budget that has contributed to significant success on building and developing the rehabilitation branch in Vietnam, especially Community-Based Rehabilitation program, and training rehabilitation staff at nation-wide level.

Appendix B: DIS-NETWORK People's Organizations

Location: 12 Nguyen Cong Tru, Hanoi

Established:

Membership:

Description:

An organization of PWDs working as volunteers, following regulations approved by the Board and all the members. It is also member of Vietnam Rehabilitation Association (VINAREHA).

Objectives:

- Exchange information and further promote social concern for the creation of an accessible environment for PWDs;
- Provide vocational training course for PWDs to bring them employment opportunities and create other services that facilitate integration into the community.

Activities:

- Cultural (e.g., take part in cultural and music shows);
- Vocational training and employment (e.g., set up a career advisory office and a registration office);
- Sports and Community activities (e.g., send members to national and city sport competitions for PWD, organize wheelchair excursions)

Association of Disabled Youth
Bright Future for People with Disabilities
Culture and Sports Club for PWD
Hanoi Association of the Blind
Rehabilitation and Vocational Training Center for Blind Youth

Appendix C: Disability Forum - DF

Location:

Khach San ATS, 33b Pham Ngu Lao, Hanoi – Vietnam

Tel/Fax: (84-4) 933.12.39, Email: forum@hn.vnn.vn

The Disability Forum of the VUFO-NGO Resource Center includes all the organizations listed below. It's aim is to promote cooperation, collaboration and better communications among NGOs, Disabled People's Organizations and Government Ministries. Any group or individual interested in the issues related to disabilities and rehabilitation is welcome to join the forum. The issues addressed by the Forum include rehabilitation and health care services, employment, inclusive education, consciousness-raising and barrier-free access to public places. Country-wide workshops are conducted approximately every six months. A regular monthly calendar of activities is distributed by email to members of the Forum and other interested parties. A web-site will be established which might include postings of employment opportunities for PWDs. Databases will be developed for a variety of items of common interest, including human resources available for training and consultation, sources and price lists for materials and services required in health care delivery, and the like.

AIFO	Associazione Italiana Amici di Raoul Follereau
CRS	Catholic Relief Services
CI	Counterpart International
DED	German Development Service
HI	Handicap International
HVO	Health Volunteers Overseas
ICRC	International Committee of the Red Cross
K2	Komitee two
MCNV	Medical Committee Netherlands Vietnam
NRL	Netherlands Leprosy Relief
ODTA	Office of Disability Technical Assistance
PSBI	Pearl S. Buck International
POWER	The International Limb Project
POF	Prosthetics Outreach Foundation
RADDA BARNEN	Swedish Save the Children
SCF	Save the Children funds/UK
VIETCOT	Vietnamese Training Center for Orthopedic Technologists
VAH	Vietnam Assistance for the Handicapped
VVAF	Vietnam Veterans of America Foundation
WCI	World Concern International
WVI	World Vision International

Appendix D: Project locations and implementation

N.	Thai Binh province (district)	Number Commune	Communes implement CBR	AIFO VINAREHA	MoH	CRS NIES	MoET UNICEF
1	Thai Binh town	12	6	0	6	0	0
2	Dong Hung	36	26	18	8	0	0
3	Tien Hai	35	15	15	0	0	0
4	Kien Xuong	40	22	0	22	0	0
5	Vu Thu	31	0	0	0	0	0
6	Quynh Phu	38	0	0	0	0	0
7	Thai Thuy	48	0	0	0	0	0
8	Hung Ha	34	0	0	0	0	0
Nam Dinh province							
1	Nam Dinh town	22	1	0	1	0	0
2	Y Yen	32	22	20	2	0	0
3	My Loc	10	10	8	2	0	0
4	Vu Ban	18	0	0	0	0	0
5	Nam Truc	20	20	0	0	0	20
6	Truc Ninh	21	0	0	0	0	0
7	Xuan Truong	20	10	0	10	0	0
8	Giao Thuy	23	23	0	0	0	23
9	Nghia Hung	25	0	0	0	0	0
10	Hai Hau	25	10	5	5	0	0
Ha Nam province							
1	Binh Luc	21	21	21	0	0	0
2	Kim Bang	21	21	12	9	0	0
3	Thanh Liem	21	10	10	0	0	0
4	Ly Nhien	23	10	0	10	0	0
5	Thy Xa town	6	0	0	0	0	0
6	Duy Tien	22	0	0	0	0	0
Hoa Binh province							
1	Lac Son	29	14	14	0	0	0
2	Kim Boi	37	10	10	0	0	0
3	Hoa Binh town	14	0	0	0	0	0
4	Da Bac	21	0	0	0	0	0
5	Tan Lac	22	0	0	0	0	0
6	Luong Son	18	18	0	0	18	0
7	Lac Thuy	14	0	0	0	0	0
8	Ky Son	20	0	0	0	0	0
9	Mai Chau	20	0	0	0	0	0
10	Yen Thuy	13	0	0	0	0	0
Ninh Binh province							
1	Hoa Lu	16	16	16	0	0	0
2	Tam Diep	7	7	7	0	0	0
3	Yen Mo	16	5	5	0	0	0
4	Nho Quan	27	0	0	0	0	0
5	Yen Khanh	20	20	0	0	20	0
6	Gia Vien	21	0	0	0	0	0
7	Kim Son	27	0	0	0	0	0
8	Thi Xa town	8	0	0	0	0	0
	Total	**954**	**317**	**161**	**75**	**38**	**43**

Appendix E: Evaluation of AIFO-VINAREHA CBR program

(carried out in June 1999 by Dr. Manoj Sharma)

Summary of results at commune, district and province levels

Findings from SWOT analysis at commune and village levels

Identified Strengths

- Identification of PWDs through house to house surveys. It was mentioned in almost all interviews as a strong component of the program. E.g., in Dong Phong commune (Tien Hai district, Thai Binh province), the CBR supervisor, an assistant doctor, was interviewed. He was able to provide an accurate data of total population in his commune of 5,668 of which 223 persons had disabilities (3.9%), 42 people needed rehabilitation (18.8% of PWDs), and five of them had been integrated within the family (11.9% of those needing rehabilitation). He was also able to present gender-wise, age-wise summary distribution of this data in a form that has been locally developed.
- Community mapping. Each of the commune health centres visited had a community map depicting location of houses of PWDs. This pictorial representation was developed during the CBR training program and serves useful purpose in tracking PWDs.
- Number of CBR workers trained. In interviews it was found that in most communes on an average a CBR worker was dealing with 2-4 PWDs. This high ratio was identified as strength of the CBR program. E.g., in Dong Phong commune, the CBR supervisor mentioned that 22 CBR workers were trained in the commune for a total of 42 people who needed rehabilitation services (one for every two PWDs). One of the CBR workers interviewed in Yen Duong village (Nam Dinh province) was able to recollect the translator, Dr. Choung (who was her trainer two years ago), an indirect reflection of the good quality of training.
- Linkage with education system. In some of the interviews it was mentioned that integration of disabled children (primarily with moving difficulty) in schools was one strength of the programme. E.g., in Dong Phuong commune, the CBR supervisor mentioned that two of the CBR workers were primary school teachers and they have been able to facilitate 13 disabled children get into normal schools.
- Production of simple prosthetic, orthotic and orthopedic devices. The CBR program has been able to provide PWDs with simple devices using locally available technology. For example, a 72 year old PWD in Dong Phuong commune who had suffered hemiplegia six months ago was able to show a bamboo made support for walking up right in his hut and a locally-crafted crutch provided by the CBR worker. In Ninh Binh province a mother of a disabled child (due to cerebral palsy) who received training as a CBR worker made a tripod appliance which assists her child.
- Emotional support to PWDs. Rehabilitation of a disabled persons is a life-long process and often times the disabled are in need of emotional support. In Yen Xa village the CBR worker and the PWD both emphasised the crucial role the CBR worker had played in providing this needed support. The PWD was a young amputee. During her period of rehabilitation she also lost her two year old son to encephalitis which added to her misery. It was reassuring to note that the CBR worker took time to visit with this person everyday during this crisis. Similarly, in Yen Duong village (Tien Hai district, Thai Binh province) PWDs mentioned that CBR workers listen to them which was very important for them.

- Use of local funds to support CBR worker. In Kim Bang district (Ha Nam province), the local government has begun experimenting with an innovative system of providing incentive in the form of giving 20-22 kg of rice per month to a CBR worker. The incentive is provided only to workers who actively participate in the program and are present for regular meetings. This was a unique feature mentioned only in this district and other districts do not have such a system in place.

Identified weaknesses

- Income generation activities. It was mentioned that one of the key barriers in integration of PWDs back in the society is ability to generate income for living. This component was started only last year by the program. In the past one year the program has been able to initiate some activities but needs to do more in this area. The income generated as a result of activities was reported to be generally low. One disabled woman interviewed in Yen Xa village (Nam Dinh province) who had started a small kiosk was able to earn just about 50,000 VNDs a month (about 3 US$). Another 35 year old disabled man (in the same village) who on loan (made available from partial AIFO funds and partial local funds) purchased a sewing machine has been able to earn up to 200,000 VNDs per month (about 14 US$). Out of this earning, he is able to pay back 6000 VNDs per month toward loan repayment to the local government. It was a widely prevalent feeling that this aspect needs to be strengthened for making the rehabilitation process "complete".
- Severe learning disability children. The interviews revealed that children with severe learning disabilities are difficult to integrate in the school system. Most of the students integrated in the school system are the ones with moving difficulty.
- Training of CBR workers. It was repeatedly mentioned in almost all interviews that training of CBR worker needed supplementation and continued reinforcements. There was a need for including modules that included more practical, "hands-on" demonstrations and skill building activities.

Identified opportunities

- Need for upgrading training of supervisors and workers. There are some deficiencies in present training and some areas are difficult to grasp, particularly, rehabilitation skill developing aspects for both CBR workers and supervisors. Upon probing it was found that such training be conducted two times per year on a recurring basis and particularly when there is no harvest April and August were suggested as best times for such training programs.
- Selection of CBR workers. In the interviews it was pointed out that the best CBR workers were family members of PWDs and efforts in future programming needs to be made to recruit such people. It was pointed out in Ninh Binh province that other people who are better CBR workers include brigade nurses (who are responsible for immunisation program) and members of the Women Union (who are responsible for family planning program).
- Traffic accidents. In the Yen Xa commune (Nam Dinh province) it was mentioned that traffic accidents are on the rise that are adding to the burden of disability in this community. It was pointed out that there will be greater need for CBR related work in coming years.

- Newsletter for CBR workers. Some CBR workers felt that there should be a periodic newsletter sent to them after training to increase their knowledge, provide them with new ideas, and keep their interests in rehabilitation-related issues alive.
- Incentives for CBR workers. All of the interviews conducted revealed (either overtly or covertly) a need for monetary compensation or other form of incentives for CBR related work. It was pointed out that all other programs provided incentives or monetary compensation for the services rendered by workers in those programs.

Identified threats

- Expansion beyond medical work is difficult. CBR supervisors and workers felt that there are numerous difficulties in extending rehabilitation beyond medical work particularly due to lack of training. Needs with regard to accomplishing ADL, self care, mobility were being met to a large extent but socialisation, communication and vocational rehabilitation aspects needed more efforts.
- Multiple tasks by CBR worker. By and large in most interviews, those CBR workers who were not family members of PWDs mentioned performing several duties. In depth interview of a CBR worker in Yen Duong village (Nam Dinh province) revealed that she was working as a kindergarten schoolteacher (four hours per day). It was difficult to comprehend that she also worked for a women's organisation (two hours per day), environmental education (two hours per day), nutrition education (two hours per day) and CBR work (two hours per day) besides agricultural harvest related work and performing usual household chores.

Findings from SWOT analysis at province and district levels

Identified Strengths

- Collection and availability of assessment data about PWDs in seven categories of disabilities at the village, commune, district and provincial levels was identified as one of strengths by all focus groups. The data collection is being done through house-to-house surveys and classifies PWDs into the WHO categories. In each focus group discussion, the participants were able to present descriptive statistical distribution from their respective communities.
- Excellent referral system. The medical health care system in Vietnam is organised at province, district, commune and village (hamlet) levels. This referral system is also utilised by the CBR program and it was mentioned in almost all focus groups as strength of the program.
- Wide representation of members in province, district, and commune level SCs. Focus groups revealed that average SC consist in eleven members. They are drawn from PWDs, families of PWDs, PC, hamlet chiefs, and different association. At Nam Dinh province it was mentioned that such a "socialised" structure of the committee has been a major strength where mutual co-operation from different people has been very good. In the case of Nam Dinh and Ninh Binh provincial SC it was also pointed out that the chairs of PC were committed to the cause of CBR and were also chair of the CBR committee such a commitment strengthens the program.
- Regularity of meetings between CBR worker and supervisor. Some focus groups mentioned this aspect as a strong component. E.g., in Tien Hai district (Thai Binh

province), it was mentioned that meetings between CBR worker and CBR supervisor are organised weekly. Generally such meetings involve sharing of tasks accomplished in the past week. In Kim Bang district (Ha Nam province), incentives are linked to attendance and presentation of weekly report by CBR worker in such meetings.

- Regularity of meetings between commune representatives and district level SC. Some focus groups revealed this as strength. E.g., in Tien Hai (Thai Binh province), it was mentioned that monthly meetings between commune representatives and district level SC are held. Generally, such meetings report activities of the past month.
- System of cross assessment between one commune and another commune utilising pre-established criteria in the areas of:

  (a) Management including follow-up at commune level, community mapping of the commune, regularity of SC meetings, and maintenance of CBR monitoring book at commune level;
  (b) Indicators of PWDs including documentation of proportion of PWDs showing improvement by total number of PWDs who need rehabilitation, proportion of PWDs integrated in the community by total number of PWDs who need rehabilitation, proportion of families involved in CBR by number of families with PWDs;

  most focus groups revealed existence of this system of rating in their communes and mentioned that their communes ranked high in such ratings.
- System of cross assessment between one district and another utilising pre-established criteria in the areas of:

  (a) proportion of communes in the district implementing CBR;
  (b) regularity of SC meetings;
  (c) length of primary training according to standardised curriculum;
  (d) replacement training courses;
  (e) annual upgrade training courses;
  (f) funds allocated by local authorities;

  most focus groups revealed existence of this system of rating in their districts and mentioned that their districts ranked good in such ratings.
- System of cross assessment between one province and another utilising pre-established criteria in the areas of:

  (a) proportion of districts in the province implementing CBR;
  (b) regularity of SC meetings;
  (c) length of primary training according to standardised curriculum;
  (d) replacement training courses;
  (e) annual upgrade training courses;
  (f) funds allocated by local authorities;

  most focus groups revealed existence of this system of rating in their provinces and mentioned that their provinces ranked good in such ratings.

- Income generation activities. Over the past few months some provinces have been able to experiment with some income generation activities for PWDs that have been quite successful. E.g., in Nam Dinh province a carpentry workshop has been established with involvement of PWDs, and sewing machines have also been distributed through a small loan. In Ninh Binh province, co-operation with provincial DoLISA has been established and some PWDs got involved in production of clothes, tooth picks, and straw rug.
- Nam Dinh province has a provincial orthopaedic centre. One of the important institutional linkages to the CBR program has been the orthopaedic centre at Nam Dinh with a 200 bed hospital, 93 staff including 16 doctors, 3 physiotherapists, and 20 nurses. This centre caters to six nearby provinces and has been able to provide effective acute rehabilitation services primarily for people with moving difficulties.
- Changes in attitudes. The Ha Nam focus group mentioned that as a result of the CBR program, people's attitude towards disabled has changed "there is less stigma". Also the attitude of PWDs has changed "they feel equal to other people".

Identified weaknesses

- SC members feel overburdened. It was mentioned that committee members are required to perform several tasks. Members are pulled in different directions from competing demands on their time from several vertical programs such as family planning, immunisation, infectious diseases control, iodine deficiency disorders programs, and others. Furthermore, meeting times sometimes conflict with harvest season and, therefore, members are not able to participate.
- System of planning from the top. It was mentioned that planning is centralised where committee members feel that they have tasks assigned from the top and are responsible for only implementation. Two of the focus groups mentioned this as a problem.
- Inactive members in the SCs. The active members of SCs are mainly people involved in the medical system and while the SC comprises of many members many of them are not active. Especially, the members from sectors other than medical do not actively participate. This inactivity in participation can be as high as 60-70 percent. Furthermore, one focus group discussion from Ha Nam province revealed that the SCs needed to meet more often.
- Limited experience with income generation activities. The CBR program has been able to experiment with introduction of income generation activities for PWDs only as a pilot project. Therefore, the learning has been limited and true success cannot be gauged at this point in time.
- Integration of CWDs other than moving disability remains a challenge. Three focus groups mentioned that mainly children with moving disabilities have been integrated in the school system; however, integrating children with other disabilities is still difficult.
- Medical budget remains low. It was mentioned in focus group discussion at Ninh Binh and Ha Nam provinces that the medical budget for all medical activities remains fairly low. In Ninh Binh it was mentioned as 20,000 VNDs per person per year (about 1.5 US$) and in Ha Nam 5,000 VNDs per person per year (about 0.33 US$).
- CBR is not a national priority. It was mentioned in most focus group discussions that CBR while has been adopted, as the chosen strategy in Vietnam still it is not a national priority and thus funding and support for these activities remains low.

- Social attitudes about disability and disabled still need to be changed. It was mentioned in focus group at Ninh Binh province that still there is need among members in the community to become aware about the needs of PWDs and need for CBR programs.

Identified opportunities

- SCs meetings. There is a need to sustain the interest of participants of SCs to continue with regular meetings. The participants of the focus group in Tien Hai district (Thai Binh province) voiced, "Perhaps some funding may be allocated for monthly meetings".
- Expansion of the programme to all communes in the district. E.g., in Tien Hai district (Thai Binh province), right now the program is present in only ten communes of the province. There are a total of 64 communes and the programme needs to be expanded to all these communes. Similarly, in Y Yen district 22 out of 32 communes have CBR.
- Enhance participation of SC members. It was mentioned that there is a need to enhance the participation of all members of the SCs at all levels. There is a need to either replace such dormant members or enhance the participation of non-active members.
- Composition of SC. It was mentioned in almost all focus groups that there is a need to enhance number of PWDs in the composition of SCs. At present the number of disabled varies between 1-2 people (10-20%) in most of the committees. This number needs to increase to at least 40-50% or 4-5 people. It is not difficult to achieve this extent of participation of PWDs, as has been the case with Nam Dinh province that has five disabled members in its committee. Participants also felt that participation of women in these committees need boosting, as at present their number also varies between 1-2.
- Training of SC members. In most focus groups it was mentioned that the training of SC members in CBR is, at present, purely "content-based" and SC members need to learn more about management processes, activity planning, conducting meetings, problem solving, and follow-up skills. The focus group discussion at Y Yen district also expressed interest in learning more about methods of IE (an approach that is aimed at including all children in normal classrooms fostering greater understanding about each others needs). The focus group in Ha Nam province mentioned the need to learn more about new techniques for dealing with cerebral palsy, more specific and specialised identification of disabilities, and advanced rehabilitation techniques needed to be learned at all levels.
- Commitment from PCs. Some focus groups mentioned that there is a need to enhance firm commitment from PC chairpersons and vice chairperson (Medical, Education and Social, who is most important person and controls 40-50% of the resources) to provide support for local funding. The internal support was seen as being vital for sustenance of the program.
- Linkage with income generation activities. The participants mentioned that the CBR program has been able to pilot test some income generation activities over the last few months with limited budget and there is need to expand this over the next few years. Participants in Ha Nam province were particularly enthusiastic about such plans and suggested introduction of credit schemes for disabled on a regular basis.
- Glasses for near-sightedness in children. Nam Dinh province participants pointed out that they have conducted a school-based survey in their province and found that 70% of the school going children are near-sighted and in need of glasses. Future programs can explore ways of addressing this disability better.

- Mass media message dissemination. It was mentioned in Ha Nam province that CBR messages could be disseminated through TV announcements (40% households have access to TV), newspaper, commune loud speakers like immunisation program. However, discussion could not reveal what succinct message needed to be disseminated.

Identified threats

- Improvement of the WHO model. In some focus groups it emerged that the approach as laid out in the WHO manual needs to be improved. E.g., at the Tien Hai district the focus group participants mentioned that, "the information provided in the WHO manual is not enough". They said, "It (the WHO manual) needs to be expanded and made more practical".
- Enhance multi-sectoral collaboration. Co-operation with other programs and other sectors was mentioned as a major challenge in the coming years. It was mentioned that each sector wanted to work separately and wanted to assign own tasks.
- Upgrading of CBR worker training was mentioned as being needed in almost all focus group discussions. However, issues pertaining to funding, availability of trainers, and availability of participants without per diem incentives were pointed out as potential threats.
- Self-sufficiency of the program still remains illusive. E.g., from the data presented at Tien Hai district, while in the past year, 38% of the funds (135 million VND) were provided by AIFO, the local government contributed 44% of the funds (157 million VND), which seemed as a promising stride. However, most of the funds contributed by the local government were utilised as part of maintenance of the referral institutional infrastructure at the district headquarters. Most focus groups believed that costs incurred by local governments in maintaining infrastructure was valuable contribution to the CBR
- Motivation of the CBR worker through incentives or monetary reimbursement as an issue was brought up at almost all focus group discussions and was one of the most fervent exchanges. There are number of CBR workers who volunteer in the hope of being compensated (like other state sponsored vertical programs) and when they are not provided any incentive after a while they just drop out.
- Income generation activities will be challenging. Based on the limited experience with such activities, Nam Dinh province participants felt that several barriers continue to exist in this regard. There is need for occupational training, supervising guided work, marketing skills training, and management skills training for such programs to be effective. Right now it was felt that the capabilities of the CBR managers are deficient in many of these aspects.

Findings from SWOT analysis at the central level

Identified strengths

- Identification of PWDs. The central team has routinely collected data about identification of PWDs from provinces and districts that have in turn collected data from communes. The method of house-to-house survey in the program was an identified strength.
- Identification of people who need rehabilitation services. Another strength of the program has been the ability to identify people who need rehabilitation services in each district.

- CBR assistance to PWDs in progressing in their rehab. goals and integrating in society. The CBR program over the period of three years of its existence has assisted several PWDs in making progress towards their rehab. goals. In gauging progress of PWDs, the program follows 23 criteria that include performance of ADL, self care, playing, schooling, taking part in family and social activities, and taking part in income generation activities.
- Expansion of the program beyond what was planned. One of the strength identified by the central team was that the CBR program has been implemented in more communes than was originally planned through the AIFO-EU support started in June 1996. This has been possible due to interest and support from local governments in many communes.
- Advanced training of team members from central level. Another strength pointed out at the central level was the training received by several of them two people in France, two people in Italy, two people in Indonesia, two people in Italy, two people in Mongolia, and two people in China.
- Translation, printing and distribution of WHO Manual. During this period the CBR program has been able to translate the manual "TCPD" and also revise several versions of this manual. Up till now about 10,000 copies have been printed in a phased manner. The latest revision has just been completed (making the language and pictorials more appropriate).
- Equipment acquisition and infrastructure strengthening. One of the strength mentioned was that the Community-Based Rehabilitation program has been able to acquire equipment at all levels.
- Training programmes conducted. During the three years the CBR program has been able to conduct the planned seminars for province and district leaders, CBR supervisor and CBR worker training at district and commune levels. Besides these the program has also conducted some special courses.
- Family network is very strong in Vietnam. In focus group discussion at central level another strength that was mentioned is that the family unit in Vietnam is very strong and the CBR program has been able to effectively use this family structure to provide for the needs of the disabled. It was also said that CBR program is being well received by the community and "people accept the approach".
- Effective referral system. It was pointed out that in Vietnam the referral system is very well established consisting of provincial/district hospitals, and commune health centres. The Community-Based Rehabilitation program has been able to link with this system and utilise it to their advantage.
- Creation of a cadre of trainers at province and district level who can train commune level workers. An important strength that was mentioned was the creation of a nucleus of trainers well versed in CBR methodology at the provincial level who can in turn train commune level supervisors and workers. The CBR program has been able to utilise this three year period to establish this cadre of professionals.
- AIFO-VINAREHA partnership support. Another strength that was hailed by all members was the excellent partnership support that has developed between the two agencies. It was mentioned that since last year, since the joining of new country representative, Mr Lorenzo Pierdomenico, the partnership has received a boost. Early years of the program had quick turnover of the staff where within the first year three people left (Ms. Ulla, Mr. Corvisieri, and Mr. Beltrame). President of VINAREHA in an individual discussion had

very kind words to say about Mr. Pierdomenico, "He is very active, wants to learn, and responds very well to our needs." In a similar vein, AIFO country representative in an individual discussion mentioned that "Prof. Nghien has done a commendable job in starting the project".

- Co-operation with other international NGOs. AIFO country representative mentioned that he has been able to initiate useful linkages with several international NGOs involved in disability-related matter work in Vietnam. AIFO has started useful work in bringing together these agencies to share a joint forum. One specific activity that has been initiated by this forum is discussion around a joint data collection process.

Identified Weaknesses

- Limited co-operation from people other than MoH. One of the weaknesses pointed out by central team members was difficulty in obtaining co-operation from members from sectors other than medical and health. The SC has few members from other sectors and those members are also not very active in participating. This problem is more acute at the central and provincial levels.
- Irregularity of SC meetings. One of the weaknesses of the program in the past three years has been the irregularity of SC meeting at the national level. The central level team felt that the same was true for many provincial and district level SCs.
- Modest documentation. One of the weaknesses mentioned was that the documentation of various activities done by the CBR program during the past three years has been inadequate. It was pointed out that documents that could be understood at all levels were few. The monitoring system relies mainly on quantitative reporting of numbers (which besides failing to capture all aspects also suffers from inaccuracy because of manual nature of computations).
- Mobilisation of local funding. VINAREHA President mentioned that they have not been able to develop a system that ensures firm commitment of local funding for CBR program. The local funding is irregular in nature and varies from one place to the other. Further most of the funding is utilised in developing infrastructure rather than supporting the program.
- Improvement in training. It was mentioned that initially the training seminars for leaders were for two days but in the last phase these were reduced to one day, similarly there was shortening in the length of training of CBR supervisors and workers from 21 days to 18 to 14 days. This has been primarily due to lack of availability of participants for longer periods of time and ability to sustain the interests of CBR workers on merely theoretical aspects.
- Need for more national commitment. It was mentioned that even though the government has endorsed the CBR approach, it has not identified it as a national priority or national program. As a result, funding commitment is not there.
- Limited experience with educational and vocational rehabilitation aspects. The CBR program has been able to initiate only some activities in the final year of the program beyond medical activities. Hence the experience is limited. The central team also felt that training at all levels in these aspects was needed.

Identified opportunities

- Need for reaching all communes in the five provinces. It was mentioned that there is a need to extend CBR to all communes within the provinces. Right now, the CBR is present in only 2 districts, and complete coverage of these districts has also not been possible.
- Retraining (or renewal training) for trained CBR workers. It was mentioned that current training of CBR worker was too short and theoretical in nature that necessitates the need for retraining of CBR workers already trained. Such retraining it was felt could be undertaken at least once a year and it was felt that nucleus of core trainers already developed at province and district levels could easily undertake this responsibility.
- Phased training of CBR workers in future. Central level members felt that in future the new training courses for CBR workers should be divided into two parts (each part for 10-14 days) that could be dovetailed with their free time right after the harvest season. This approach it was felt could improve learning. It was also mentioned that future training should include aspects of management training.
- CBR leaders training. It was mentioned that CBR leaders training needs to include more specific information about involving political leaders, ways of ensuring participation in SC meetings, and ways to mobilise local funding. It was also felt that there is a need to enhance capabilities of learners in SCs to be able to specifically articulate learning expectations. The AIFO representative expressed frustration in this regard.
- Decentralised decision-making. The central team members felt that VINAREHA may benefit from adopting a more egalitarian and inclusive decision making process that involves all SC members and even involves people from other sectors. It was felt that even though this process may be time consuming and very difficult, it will be beneficial because it will enhance ownership of the program among all members, improve the quality of decisions, and help in developing a shared vision.
- Need for administrative co-ordinator. It was felt by many people of the central team
- that if a full-time administrative co-ordinator was hired by VINAREHA that could improve the functioning. Such a person needs to be young, able to travel, be proficient in verbal and written communication skills (English), be responsible for ensuring efficient communication between all levels, and assist in decentralising.
- Inclusive Education. Some members expressed the need to learn more about IE that has been introduced through the NIES in some other districts. AIFO representative is particularly keen in introducing this approach. He has also attended some local specialised training in this regard.

Identified threats

- Participation from other sectors. It was mentioned that eliciting participation from other sectors at all levels continues to be a challenge particularly at central and provincial levels.
- Local funding. The situation with local funding remains temporary. Participants felt that unless CBR becomes a national program it is difficult to have assurance in this regard.
- Lack of knowledge about aspects other than medical. Some of the members of the team were humble enough to admit that they had limited knowledge and expertise with regard to aspects other than medical. They felt that if they did not receive training and had to pursue activities like building credit unions, pursuing IE programmes, it would be a
- potential threat.

Appendix F: Questionnaires

1A GENERAL INFORMATION AT PROVINCE LEVEL	2A GENERAL INFORMATION AT DISTRICT LEVEL
Province:	District: .....
Total area:	Province: .....
Total population:	Total population: .....
Number of districts:	Total number of communes: .....
Number of communes:.....	Total number of PWDs: .....
Number of Ethnic minorities in province (name and percentage of each ethnic):.....	Number of PWD in need of rehabilitation: .....
Name of the districts implementing CBR program:	List of Steering Committee members: ....
Number and name of districts supported by local authority or other donors (specify):.....	Participation of the community: ....
Equipment provided by AIFO-VINAREHA:.....	Participation of the PWDs' Families: ....
Register situation:	PDO and activities situation: ....
Activity of Steering Committee:.....	
Participation of the community:.....	
Participation of PWD's family:	
Disabled People Organization and activity situation:	

2B LIST OF STEERING COMMITTEE MEMBERS

District: ..... **Province:** .....

N.	Name	Function in the Steering Committee	Occupation & working place	Active not active

2C LIST OF TRAINED CBR WORKER

District: ..... **Province:** .....

N.	Name	Profession	Number of commune in charge	Active not active

2D LIST OF PWDs

District: ..... **Province:** .....

Type of disability	0-15 years old		16-60 years old		> 60 years old	
	Male	Female	Male	Female	Male	Female
Difficulty on seeing						
Difficulty on moving						
Difficulty in learning						
Strange behavior						
Difficulty on hearing/speaking						
Epilepsy						
Multi-disability						
Others						
Sub-total						
Total						

2E LIST OF PWDs IN NEED OF REHABILITATION

District: ..... **Province:** .....

Type of disability	0-15 years old		16-60 years old		> 60 years old		Total
	Male	Female	Male	Female	Male	Female	
Difficulty on seeing							
Difficulty on moving							
Difficulty in learning							
Strange behavior							
Difficulty on hearing/speaking							
Epilepsy							
Others							
Sub-total							
Total							
PWDs have shown progress							
PWDs integrated in the society							
PWDs death							
PWDs newly detected							

3A GENERAL INFORMATION AT COMMUNE LEVEL

Commune: .....

District: .....

Province: .....

Total population: .....

Total number of PWD: .....

Number of PWD in need of rehabilitation: .....

List of Steering Committee members: .....

Participation of the community: .....

Participation of the PWDs' families: .....

PDO and activities situation: .....

3B LIST OF STEERING COMMITTEE MEMBERS

Commune: ..... **District:** ..... **Province:** .....

N.	Name	Function in the Steering Committee	Occupation & working place	Active not active

3C LIST OF TRAINED CBR WORKER

Commune: ..... **District:** ..... **Province:** .....

N.	Name	Profession	N. of PWD in charge	Fits	Active not active

3D LIST OF PWDs

Commune: ..... District: ..... Province: .....

Type of disability	0-15 years old		16-60 years old		> 60 years old		Total
	Male	Female	Male	Female	Male	Female	
Difficulty on seeing							
Difficulty on moving							
Difficulty in learning							
Strange behavior							
Difficulty on hearing/speaking							
Epilepsy							
Multi-disability							
Others							
Sub-total							
Total							

3E LIST OF PWDs IN NEED OF REHABILITATION

Commune: ..... District: ..... Province: .....

Type of disability	0-15 years old		16-60 years old		> 60 years old		Total
	Male	Female	Male	Female	Male	Female	
Difficulty on seeing							
Difficulty on moving							
Difficulty in learning							
Strange behavior							
Difficulty on hearing/speaking							
Epilepsy							
Others							
Sub-total							
Total							
PWDs have shown progress							
PWDs integrated in the society							
PWDs death							
PWDs newly detected							

3F LIST OF PWD IN NEED OF REHABILITATION AT VILLAGE LEVEL

Village: ..... Commune: .....

District: ..... Province: .....

Type of disability	0-15 years old		16-60 years old		> 60 years old		Total
	Male	Female	Male	Female	Male	Female	
Difficulty on seeing							
Difficulty on moving							
Difficulty in learning							
Strange behavior							
Difficulty on hearing/speaking							
Epilepsy							
Others							
Sub-total							
Total							
PWDs have shown progress							
PWDs integrated in the society							
PWDs death							
PWDs newly detected							

4A INFORMATION ON CBR WORKER

First and given name of CBR worker: .....

.....

Date of birth:

.....

Male: ..... Female:.....

Married: ..... Single: .....

Divorced: ..... Widowed : .....

How many people do you have to nourish ?:

.....

.....

Address: .....

.....

.....

How many PWDs do you have to help to do exercises on rehabilitation ?:

.....

.....

What is your schedule to visit PWDs ?

1-2 times/week: .....

2 times/month: ..... Rarely: .....

What is your backgroud ?:.....

.....

.....

Date when you have been engaged in CBR programme ?:

.....

.....

What changes do you desire for CBR training programme e.g. : Do you need any supplemental training and / or any helps in order to improve your work for CBR programme?

.....

.....

.....

.....

.....

Date Signature

4B I. INFORMATION ON PWDs

First and given name: .....

Date of birth:.....

Male: ..... Female: .....

Married: ..... Single: .....

How many children do you have ?: .....

Address: .....

Are you salaried ?: .....

Which educational level have you reached ?

P.ry school: ..... Sec.ry school: ....

University: ..... Postgraduate: .....

Which kind of capacity has been diminished ?

Difficulty on seeing: .....

Difficulty on moving: .....

Loss of sensation:.....

Strange behaviours:.....

Difficulty on hearing and speacking:.....

Epilepsy:.....

Multi isability.....

What kind of special assistance do you need ?

Education:..... Appliances: .....

Credit: ..... Vocational training: .....

Date Signature

II. INFORMATION ON PWD's FAMILY

Name of father / mother or any relative: .....

How many children in the family that parents still have to rear ?.....

How many sons: ..... How many daughters: .....

Does PWD or CWD go to school ?.....

If no why ?.....

How far from your house to school ?.....

Do PWD's parent earn family's living ?.....

Date Signature

Appendix G: Literatures

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Appendix H: Contacts

1. Chairman and vice-chairman of People's Committee of Ha Nam, Thai Binh, Ninh Binh, Nam Dinh, Hoa Binh provinces.
2. Directors of Health Bureau of Ha Nam, Thai Binh, Ninh Binh, Nam Dinh, Hoa Binh provinces.
3. Prof. Nguyen Xuan Nghien, head of rehabilitation at department Bach Mai hospital Hanoi, Prof. at Hanoi Medical College, and also President of VINAREHA.
4. Tran Trong Hai MD. PhD, Director International Co-operation Department, head of Rehabilitation Department (NIP), and Secretary General of VINAREHA.
5. Prof. Bui Tung, director Orthopedics and Rehabilitation Institute department, MoLISA.
6. Mr. Nguyen Van Toan, vice-director, orthopedic factory, Ba Vi, Hanoi.
7. Julie B. Yoder, former Assistant Director of Vietnam Assistance for the Handicapped - Office of Disability Technical Assistance (VNAH-ODTA).
8. Mr. Wilfried Raab, team leader & senior Adviser C.O.P., VIETCOT.
9. Mrs. Luu Thi Khuyen credit program assistance Catholic Relief Service (CRS).
10. Dr. Le Van Tac Reseacher-Trainer on Special Education program office NIES.
11. Mr. Pham Minh Muc Researcher-Trainer, Program Assistant.
12. Dr. Pham Quang Lung, national expert on rehabilitation and vice-president of VINAREHA.
13. Dr. Tran Van Chuong, deputy chairman department of rehabilitation Bach Mai hospital and secretary of VINAREHA.
14. Dr. Cao Minh Chau, department of rehabilitation Bach Mai hospital, and members of VINAREHA's SC.
15. Mr. Do Ba Khoa deputy-director, and Mr. Nguyen Quy Hai, national program coordinator of PACCOM.
16. Mr. Jan Robjin, NLR representative, and Mrs. Kerry Fisher, Orthotic/Prosthetist VVAF.

NHÀ XUẤT BẢN Y HỌC

COMMUNITY – BASED REHABILITATION PROGRAM VIETNAM

DIRECTION,APPROACH, ACHIEVEMENTS CONSTRAINTS

PHỤC HỒI CHỨC NĂNG DỰA VÀO CỘNG ĐỒNG, GIẢI PHÁP THỰC HIỆN Ở VIỆT NAM

Chịu trách nhiệm xuất bản

HOÀNG TRỌNG QUANG

NGUYỄN THỊ KIM LIÊN

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Sửa bản in: **Lorenzo Pierdomenico**

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